

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G232 8/7/58 881

CERTIFICATE OF DEATH

68659

8697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>anne arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>3 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville 58 Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Nathaniel</u> Last <u>Addison</u>				4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/8/1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>charterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Balt.</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Will Addison</u>				14. MOTHER'S MAIDEN NAME <u>Edith Queen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Medical Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypostatic pneumonia</u> DUE TO (c) <u>Cerebral cortical atrophy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/28/58</u> , 19 <u>58</u> , to <u>8/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/2</u> , 19 <u>58</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilbur A. Hamman</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville 58 Hospital</u> DATE SIGNED <u>8/2/58</u>			
PHYSICIAN'S NAME (Type) <u>Wilbur A. Hamman M.D. Crownsville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 5, 1958</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel Hill</u> ADDRESS <u>1631 Druid Hill Ave</u>				24a. REC'D BY REGISTRAR <u>Aug 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

8663 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Ed. C. General</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
f. STREET ADDRESS <u>196 Gloucester</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lenore Elizabeth Hensley Alexander</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>6</u> - Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Lighman Hensley</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Helen Hambleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Robert Leeders</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascularles</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>August 6, 1958</u> , that I last saw the deceased alive on <u>August 6, 1958</u> , and that death occurred at <u>835 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans, M.D.</u>		ADDRESS (Street, city or town, state) <u>31 Smith Center Ave</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLA WANS</u>		DATE SIGNED <u>8/8/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-9-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ledar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Scyler Sims</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>Alf Beach</u>		24b. REGISTRAR'S SIGNATURE <u>Alf Beach</u>	
DATE <u>AUG 11 '58</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8664 CERTIFICATE OF DEATH

Reg. Dist. No.

08661

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>196 Gloucester</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas W. Alexander</u>				4. DATE OF DEATH Month Day Year <u>8-7-1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/20/84</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Pharmacist</u>		11. BIRTHPLACE (State or foreign country) <u>Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>10</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Robert Seeders</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vasc. Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 27</u> , 19 <u>58</u> , to <u>Aug 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 7</u> , 19 <u>58</u> , and that death occurred at <u>1:55 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice F. Khawans</u> M.D.				ADDRESS (Street, city or town, state) <u>31 South 4th St. Annapolis, Md</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE F. KHAWANS</u>				DATE SIGNED <u>8/8/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-9-58</u>		<u>Cedar Bluff</u>		<u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15, 1920</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10, 1945</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10, 1965</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. John Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. OFFICIAL SEAL <i>Seal of the State Department of Health</i></p>	

M



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND VITALS ACT, CHAPTER 10, SECTION 10-101, AS AMENDED.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9-17-58 at
8698
CERTIFICATE OF DEATH

08662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A-A-C b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Maryland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3001-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle (BAYLOR) Last Bailey		4. DATE OF DEATH Month 8 Day 2 Year 1958	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 March 1901
9. AGE (In years, last birthday) 57 1/2		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm helper.		10b. KIND OF BUSINESS OR INDUSTRY Farm helper.	
11. BIRTHPLACE (State or foreign country) not in record		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William James Bailey		14. MOTHER'S MAIDEN NAME not recorded	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) not recorded		16. SOCIAL SECURITY NO. not recorded	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/31 , 1958, to 8/2 , 1958, that I last saw the deceased alive on 8/21 , 1958, and that death occurred at 1:40 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownville State Hospital DATE SIGNED August 2, 1958			
ACTUAL SIGNATURE L. Benedict M.D.		M.D. Crownville, Md.	
PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		M.D. Crownville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/58	
22c. NAME OF CEMETERY OR CREMATORY St. Anthony		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Wilson		ADDRESS 1000 Branthey Ave	
24a. REC'D BY REGISTRAR 8/5/58		24b. REGISTRAR'S SIGNATURE W. Beach	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DATE OF DEATH

DECEASED'S NAME

SEX

AGE

PLACE OF BIRTH

DATE

TIME

(Signature)

DECEASED'S ADDRESS

CITY

STATE

COUNTY

DECEASED'S OCCUPATION

CAUSE OF DEATH

DECEASED'S SEX

DECEASED'S AGE

DECEASED'S ADDRESS

DECEASED'S CITY

DECEASED'S STATE

DECEASED'S COUNTY

DECEASED'S OCCUPATION

DECEASED'S CAUSE OF DEATH

DECEASED'S DATE OF DEATH

DECEASED'S TIME OF DEATH

DECEASED'S PLACE OF BIRTH

DECEASED'S SEX

DECEASED'S AGE

DECEASED'S ADDRESS

DECEASED'S CITY

DECEASED'S STATE

DECEASED'S COUNTY

DECEASED'S OCCUPATION

(Signature)

(Signature)

(Signature)

(Signature)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08663

8699

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Box 275 Route 5</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 607</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Reginald</u> <u>Isaiah</u> <u>Baker</u>				4. DATE OF DEATH <u>August 22rd.</u> <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/17/29</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Baker</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Pack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Rhoda Baker (mother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, fractures of both legs and</u> <u>812x</u> DUE TO <u>multiple other injuries of body and limbs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was hit by an automobile while walking on the road.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was hit by an automobile while walking on the road.</u>					
20c. TIME OF INJURY Month, Day, Year <u>8/15</u> <u>8/22/58</u> <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 607</u>		20f. (City or town) (County) (State) <u>Pasadena A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/22/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Church</u>		22d. LOCATION (City, town, or county) (State) <u>Pasadena, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hays</u>				24a. REC'D BY REGISTRAR <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

2

MSME

FOR STATE
HEALTH DEPT.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: []
2. SEX: []
3. AGE: []
4. DATE OF BIRTH: []
5. PLACE OF BIRTH: []
6. OCCUPATION: []
7. CAUSE OF DEATH: []
8. MANNER OF DEATH: []
9. SIGNATURE OF EXAMINER: []
10. DATE OF EXAMINATION: []

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>a a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>a a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles E. Basil</i>		4. DATE OF DEATH Month <i>8</i> - Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-13-1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer-Rel. News Paper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Annapolis Md</i>	
11. BIRTH PLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George A. Basil</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Francis E. Basil</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Interosseous Heart Disease</i> (c) <i>1 yr.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jun 10</i> , 19 <i>58</i> , to <i>Aug 13</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Aug 13</i> , 19 <i>58</i> , and that death occurred at <i>8:50</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James R. Martin</i>		M.D. <i>Annapolis 1 Md</i>	
PHYSICIAN'S NAME (Type) <i>JAMES R MARTIN</i>		DATE SIGNED <i>8/13/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-15-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor, Sins</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital, or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be fitted with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1920</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>J. H. Jones</i>		11. SIGNATURE OF WITNESSES <i>W. H. Smith, J. K. Brown</i>		12. SIGNATURE OF REGISTRAR <i>W. H. Smith</i>	
13. PLACE OF BIRTH <i>Baltimore, Md.</i>		14. DATE OF BIRTH <i>Jan 15 1875</i>		15. OCCUPATION <i>Teacher</i>	
16. MARITAL STATUS <i>Married</i>		17. EDUCATION <i>High School</i>		18. RELIGION <i>Catholic</i>	
19. PREVIOUS ILLNESS <i>None</i>		20. PREVIOUS SURGERY <i>None</i>		21. PREVIOUS TRAUMA <i>None</i>	
22. PREVIOUS ALCOHOLIC DRINKING <i>Occasional</i>		23. PREVIOUS TOBACCO SMOKING <i>Occasional</i>		24. PREVIOUS DRUG USE <i>None</i>	
25. PREVIOUS RHEUMATISM <i>None</i>		26. PREVIOUS GOUT <i>None</i>		27. PREVIOUS DIABETES <i>None</i>	
28. PREVIOUS HYPERTENSION <i>None</i>		29. PREVIOUS BRONCHITIS <i>None</i>		30. PREVIOUS PNEUMONIA <i>None</i>	
31. PREVIOUS TUBERCULOSIS <i>None</i>		32. PREVIOUS MALARIA <i>None</i>		33. PREVIOUS SYPHILIS <i>None</i>	
34. PREVIOUS OTHER DISEASES <i>None</i>		35. PREVIOUS INJURIES <i>None</i>		36. PREVIOUS POISONING <i>None</i>	
37. PREVIOUS OTHER CAUSES <i>None</i>		38. PREVIOUS OTHER FACTORS <i>None</i>		39. PREVIOUS OTHER NOTES <i>None</i>	
40. PREVIOUS OTHER COMMENTS <i>None</i>		41. PREVIOUS OTHER REMARKS <i>None</i>		42. PREVIOUS OTHER OBSERVATIONS <i>None</i>	

RECEIVED
JAN 16 1920
BALTIMORE, MD.

8666 CERTIFICATE OF DEATH

08665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
c. LENGTH OF STAY IN b 3 days		d. STREET ADDRESS Box 277 Rt.#4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Franklin Last Beatty Sr.		4. DATE OF DEATH Month August Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY real estate	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Beauregard Beatty		14. MOTHER'S MAIDEN NAME Sarah Tawney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-12-6216	
17. INFORMANT Christina S. Beatty		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ureteral compression DUE TO (c) Squamous CA of Rectum			INTERVAL BETWEEN ONSET AND DEATH 1 mo 1 mo 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March, 1958 to 8/23/58 , that I last saw the deceased alive on 8/23/58 , 19____, and that death occurred at 7:58 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin Davis, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 98 Cathedral St, Annapolis Maryland 8/25/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8-27-58	22c. NAME OF CEMETERY OR CREMATORY Hereford Baptist	22d. LOCATION (City, town, or county) (State) Hereford, Parkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		ADDRESS 622 York Rd., Towson 4, Md	24a. REC'D BY REGISTRAR DATE AUG 28 '58
		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8700 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P. O. Severna Park</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address). <u>Hollywood on the Severn.</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edward Bradford Blaney Jr.</u>			4. DATE OF DEATH <u>August 22rd.</u> 19 <u>58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/58</u>	9. AGE (In years last birthday) yrs. <u>1</u> <u>23</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Edward Bradford Blaney Sr.</u>		
14. MOTHER'S MAIDEN NAME <u>Doris Ellen Rdtzker</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT Address <u>Mrs. Doris E. Blaney (mother)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic pneumonitis</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles S. Petty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/23/58</u>	
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>					
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 25 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto Natl Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore Md</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benard A. Fink</u>		ADDRESS <u>Glen Burne Md</u>		24a. REC'D BY REGISTRAR <u>AUG 25 58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

2063251XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8667 CERTIFICATE OF DEATH

08668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs</u>		d. STREET ADDRESS <u>1205 Bolton Street #17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HELEN LUCAS BROOKS</u>		4. DATE OF DEATH <u>8-2-58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Eden, Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Luteroo G. Lucas</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Dillehunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-05-0619</u>	
17. INFORMANT <u>Son, Choukey Brooks</u>		Address <u>1321 35th St N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1956</u> , 19____, to <u>1958</u> , 19____, that I last saw the deceased alive on <u>8-2-58</u> , 19____, and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		ADDRESS (Street, city or town, state) <u>Severna Park</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>8-2-58</u> <u>M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Son</u>		24a. REC'D BY REGISTRAR <u>Aug 5 '58</u>	
ADDRESS <u>Balto-17, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8668

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Herbert Last BROWN				4. DATE OF DEATH Month August Day 5 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1880	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J oseph Brown				14. MOTHER'S MAIDEN NAME Mary Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Grace G. Brown Address Churchton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, brain 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic hypertension 444 DUE TO (c) 2 Years							INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus 260							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 4, 1958 , to August 5, 1958 , that I last saw the deceased alive on August 5, 1958 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 Clay St., DATE SIGNED 8/5/58							
ACTUAL SIGNATURE R. L. Richardson				M.D. 110 Clay St.,			
PHYSICIAN'S NAME (Type) R. L. Richardson				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-58		22c. NAME OF CEMETERY OR CREMATORY Brown's Cemetery		22d. LOCATION (City, town, or county) (State) Churchton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hardesty Fun. Home, Salisbury, Md.				24a. REC'D BY REGISTRAR AUG 6 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon page 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10021

22. 11. 2007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08670

CERTIFICATE OF DEATH

Reg. Dist. No. 27

8701

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herald Harbor (Found at) Unknown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Ft George G. Meade, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Last Calwonsen		4. DATE OF DEATH Month August Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Oct 1931
9. AGE (In years lost, birthday) 26 yrs.		IF UNDER 1 YEAR Months 26 Days 17 Hours 19 Min. 58	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Block Maker	11. BIRTHPLACE (State or foreign country) Phillipsburg in Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William C. Calwonsen	
14. MOTHER'S MAIDEN NAME Alice Elizabeth (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) is at present	
16. SOCIAL SECURITY NO. 195-22-1082		17. INFORMANT Mil Pers Office, Hq. Ft. George G. Meade, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 850X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell from an outboard motorboat			INTERVAL BETWEEN ONSET AND DEATH DOA
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Elmer G. Lennhardt, Md. at Herald Harbor, Maryland Details unknown - pronounced dead by Co. Med. Examiner	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 9:30 p. m. Aug 17 1958	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Round Bay, water	20f. (City or town) (County) (State) Herald Harbor Anne Arundel, Md.
21. I certify that I attended the deceased from 1931 to 1958 , that I last saw the deceased alive on 1958 and that death occurred at 9:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Phillipsburg, N.J. DATE SIGNED Aug 21 58			
ACTUAL SIGNATURE Gerard Noteboom M.D.			
PHYSICIAN'S NAME (Type) Gerard Noteboom, Capt. MC, Fort George G. Meade, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Aug. 22, 1958	22c. NAME OF CEMETERY OR CREMATORY Fairmount	22d. LOCATION (City, town, or county) (State) Phillipsburg, N.J.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		24a. REG'D BY REGISTRAR Aug 21 58 DATE	
24b. REGISTRAR'S SIGNATURE William S. Adams			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF COLUMBIA COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		d. STREET ADDRESS 3508 RODMAN STREET	
3. NAME OF DECEASED (Type or print) First ALICE Middle ANDREWS Last CLAUDE		4. DATE OF DEATH Month AUG. Day 22 Year 1958	
5. SEX F	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 NOV 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) MINNESOTA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE (N) ANDREWS		14. MOTHER'S MAIDEN NAME KATHERINE (N) TAINOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT USNH ANNAPOLIS, MD.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE DUE TO 825X LACERATION, LUNGS, BILATERAL WITH PARTIAL RIGHT PNEUMOTHORAX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) FRACTURE/MULTIPLE, RIGHT AND LEFT THORACIC CAGES DUE TO (c) 2 DAYS		INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL CONCUSSION: RETROPERITONEAL HEMORRHAGE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PASSENGER IN AUTOMOBILE ACCIDENT	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11:30 AUG. 20 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) ANNAPOLIS (ANNE ARUNDEL) MD.		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE <i>Elmer Lindhardt</i> EXAMINER'S NAME (Type) ELMER L. LINDHARDT M.D.	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 22 AUG. 1958		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-25-1958	22c. NAME OF CEMETERY OR CREMATORY Academy Court	22d. LOCATION (City, town, or county) (State) Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR AUG 26 58	24b. REGISTRAR'S SIGNATURE <i>William S. Frank</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the registrar prior to burial, cremation, or removal.

1000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED: _____</p>		<p>2. SEX: _____</p>		<p>3. AGE: _____</p>	
<p>4. OCCUPATION: _____</p>		<p>5. MARITAL STATUS: _____</p>		<p>6. PLACE OF BIRTH: _____</p>	
<p>7. DATE OF DEATH: _____</p>		<p>8. TIME OF DEATH: _____</p>		<p>9. PLACE OF DEATH: _____</p>	
<p>10. CAUSE OF DEATH: _____</p>		<p>11. MANNER OF DEATH: _____</p>		<p>12. SIGNATURE OF EXAMINER: _____</p>	
<p>13. SIGNATURE OF WITNESS: _____</p>		<p>14. SIGNATURE OF WITNESS: _____</p>		<p>15. SIGNATURE OF WITNESS: _____</p>	

8670

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cape St Clair</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A A General</i>		d. STREET ADDRESS <i>R. F. D. Annapolis</i>	
3. NAME OF DECEASED (Type or print) First <i>Roland</i> Middle <i>N.</i> Last <i>Como</i>		4. DATE OF DEATH Month <i>8</i> - Day <i>26</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 13 - 1896</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Naval Academy</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Como</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Duval</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Roland E. Como</i>		Address <i>908 Francis St City</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gastro hemorrhage</i> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>thrombocytopenia</i> DUE TO (c) <i>Ch. Myelocytic leukemia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>1 mon</i> <i>6 mon</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 1958, to <i>8-26</i> , 1958, that I last saw the deceased alive on <i>8-26-58</i> , 1958, and that death occurred at <i>4 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>121 Cathedral St - 8-27-58</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley Annapolis Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug 30-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cemt</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sims</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and retain them for the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3670

Reg. Dist. No.

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1925</i></p>	
<p>5. PLACE OF BIRTH <i>Washington, D.C.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1948</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1970</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. John Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 232 8-22-58 et.

CERTIFICATE OF DEATH

08673

Reg. Dist. No.

8702

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>Luzerne</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Old Burnie</i>				c. LENGTH OF STAY IN 1b <i>3 1/2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nanticoke</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>412 Pine Terrace</i>				d. STREET ADDRESS <i>02X-1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>George John COOMBS</i>				4. DATE OF DEATH Month Day Year <i>13 August 1958</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>26 November 1890</i>	
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Iron engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Coal</i>		11. BIRTHPLACE (State or foreign country) <i>Nanticoke, Pa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Yes</i>							
13. FATHER'S NAME <i>William Henry Coombs (dec)</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Jane Bath (dec)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Mrs Dorothy Clark (daughter)</i>				Address <i>Same address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X Cerebral metastases</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of prostate</i> DUE TO (c) <i>—</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Metastases to bones and lungs</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>— 19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>6 Oct</i> , 1954, to <i>present</i> , 1958, that I last saw the deceased alive on <i>24 June</i> , 1958, and that death occurred at <i>12:45 PM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Hubert F. Manuzak</i> M.D. <i>901 EDGERLY RD</i> <i>13 Aug 1958</i>							
PHYSICIAN'S NAME (Type) <i>HUBERT F. MANUZAK</i>				<i>GLEN BURNIE, MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-16-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Nanticoke</i>		22d. LOCATION (City, town, or county) (State) <i>Nanticoke Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard H. Hubbard</i> ADDRESS <i>4107 Wilkens Ave. 29</i>				24a. REC'D BY REGISTRAR <i>—</i> DATE <i>Aug 15 58</i>		24b. REGISTRAR'S SIGNATURE <i>Orlando S. ...</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. M. C. O</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>WASH. D. C.</u> b. COUNTY <u>47X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D C</u> ✓ d. STREET ADDRESS <u>433 Leabourn St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CECIL</u> Middle <u>A.</u> Last <u>CORDELL</u>				4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 aug 1914</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisory Clerk Dept of Army</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tipton Kansas</u>			
11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>George Cordell</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW #2</u>				16. SOCIAL SECURITY NO. <u>WW #2</u>			
17. INFORMANT <u>Leonard A. Shoemaker</u> Wash D.C.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE INJURIES</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-accident 301-2 cars</u>				20c. TIME OF INJURY Month, Day, Year Hour <u>8:12</u> o. m. <u>1958</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>A.A.</u>				(County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. P. Linhardt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8/5/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 6-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros 1661 1st Ave SE</u>				24a. REC'D BY REGISTRAR <u>Alb. Seach</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE			
DATE <u>AUG 5 '58</u>				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8672

CERTIFICATE OF DEATH

08675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>A.A. GENERAL</u>		d. STREET ADDRESS <u>150 Eucalyptus</u>	
3. NAME OF DECEASED (Type or print) <u>Russell</u> First <u>E</u> Middle <u>CURRY JR.</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-1958</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RUSSELL E. CURRY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE L. BEATTY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Russell E. Curry</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>760.0</u> DUE TO <u>Subarachnoid hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 14, 1958</u> to <u>Aug 16, 1958</u> , that I last saw the deceased alive on <u>Aug 15, 1958</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil H. Sims</u> M.D.		DATE SIGNED <u>95 Cathedral St</u>	
PHYSICIAN'S NAME (Type) <u>NEIL H. SIMS</u>		<u>Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WILKES CHAPEL</u>	22d. LOCATION (City, town, or county) (State) <u>HUNTERLY VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor-Sons</u> ADDRESS <u>Annapolis MD</u>		24a. REC'D BY REGISTRAR <u>AUG 19 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>

2063263XU4

at the Government Bank

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08677

8703

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEEN BURNIE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
CITY OR TOWN <u>GLEEN BURNIE</u>		LENGTH OF STAY (in this place) <u>10 Mo</u>		STREET ADDRESS <u>1</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOHN LEE DOWELL</u>				<u>Aug 5 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>7-20-1890</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seaboard Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Benjamin Dowell</u>				14. MOTHER'S MAIDEN NAME <u>Saura A. Chambers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-34-2258 A</u>		17. INFORMANT & ADDRESS <u>John Lee Dowell - Glen Burnie, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>ARTERIO SCLEROTIC HEART</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>DUE TO DISEASE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 2</u> , 19 <u>58</u> , to <u>Aug 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 2</u> , 19 <u>58</u> , and that death occurred at <u>4:15 A</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph A. ...</u> M.D. <u>102 B & A Bldg. N.E. Calvert Co., Md.</u>				DATE SIGNED <u>8-5-1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 8, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		LOCATION (City, town, or county) <u>Lusby Calvert Co., Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. O. Harkness & Son - Mutual, Md</u>			
DATE <u>AUG 8 '58</u>							

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 57TH STREET
CHICAGO, ILL. 60637
TEL. 773-936-5000
FAX 773-936-5001
WWW.CHICAGO.EDU

8704

CERTIFICATE OF DEATH

08678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA, PO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BROOKLYN PARK MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>17 HAMMOND LANE</u>	
3. NAME OF DECEASED (Type or print) First <u>MARYANNA</u> Middle <u>DRZYMALA</u> Last <u>DRZYMALA</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/1874</u>
9. AGE (In years last birthday) yrs. <u>84</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CASPER MARDAS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS ANNA KENNY</u>		Address <u>7 HAMMOND LANE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A. S. C. V. H.D.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 195 <u>1</u> , to <u>13 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 Aug 58</u> , 19 <u>58</u> , and that death occurred at <u>7 A</u> .M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4416 Ritchie Hwy 13 Aug 58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>	22d. LOCATION (City, town, or county) (State) <u>1300 DUNDALK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber</u>		ADDRESS <u>705 S. Quinn St</u>	
24a. REC'D BY REGISTRAR <u>AUG 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 2 of 2

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES J. HANNAH		M		44		10/18/1918		10:30 AM		Home		Pneumonia		Natural		J. J. Hannah		J. J. Hannah	
11. Name of informant		12. Address		13. City		14. State		15. Country		16. Date of birth		17. Sex		18. Age		19. Signature of informant		20. Signature of registrar	
J. J. Hannah		100 North Street		Boston		Mass		U.S.A.		10/18/1918		M		44		J. J. Hannah		J. J. Hannah	
21. Name of informant		22. Address		23. City		24. State		25. Country		26. Date of birth		27. Sex		28. Age		29. Signature of informant		30. Signature of registrar	
J. J. Hannah		100 North Street		Boston		Mass		U.S.A.		10/18/1918		M		44		J. J. Hannah		J. J. Hannah	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, OCT. 18

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08679

8705

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Light Street Avenue</u>		d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Elzey Duvall</u>		4. DATE OF DEATH Month Day Year <u>August 8th, 1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/70</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watch repairer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arundel Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Rosetta Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>219-16-0853</u>	
17. INFORMANT <u>Mrs. Helen G. Fulton (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio vascular diseases.</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>44</u> , to <u>Aug. 8th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/5/58</u> , 19 <u>58</u> , and that death occurred at <u>9.15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED <u>8/8/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug. 11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. T. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Brown</u>	

8673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08680

Reg. Disf. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAY RIDGE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A A. GENERAL</u>		d. STREET ADDRESS <u>148 RIVER DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>F</u> Last <u>Elliott</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-1892</u>
9. AGE (in year last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>16</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY PRODUCTS</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>HARRY W. ELLIOTT</u>		14. MOTHER'S MAIDEN NAME <u>EMMA L. FORNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>Norma F. Elliott</u>	
17. INFORMANT <u>Norma F. Elliott</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarct</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>XXXX</u> <u>8/16/58</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>water</u>	20f. (City or town) (County) (State) <u>Bay Ridge AA Maryland</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Forney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. T aylor Sires</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 19 '58</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

8706

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		09 13.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 38 Edgewood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Ennals		4. DATE OF DEATH Month 8 Day 21 Year 19 58					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1890		9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Packer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Issah Ennals		14. MOTHER'S MAIDEN NAME Hannah					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 214-07-8037		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Hypostatic pneumonia DUE TO Hypertensive Cardio-vascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 21, 19 58 to August 21, 19 58 , that I last saw the deceased alive on August 21, 19 58 , and that death occurred at 12:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 21 1958		22c. NAME OF CEMETERY OR CREMATORY Waughn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold		ADDRESS Cambridge Md		24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potapsco Park</u>		c. LENGTH OF STAY IN 1b <u>11 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>304 Elizabeth Ave.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Otha</u> Middle <u>Lee</u> Last <u>Finney</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19th.</u> Year <u>19 58</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/9/79</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Abraham Finney</u>				14. MOTHER'S MAIDEN NAME <u>Clarice Conkish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Virgie Murdock (foster daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Hypertensive cardio vascular diseases.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/19/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Adelphi Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chay O Wilson</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8708 CERTIFICATE OF DEATH

08683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lake Shore</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>T.</u> Last <u>Ford</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lin. Heights</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard T Ford</u>				14. MOTHER'S MAIDEN NAME <u>Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Mary Ellen Ford, Same as No. # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Aug 23</u> , 19 <u>58</u> , to <u>Aug 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 28</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mountain Rd. Pasadena Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR MD</u>				ADDRESS <u>PASADENA MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-2-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Butnic</u>				ADDRESS <u>Glen Butnic, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED MARY ANN BROWN		SEX F	
DATE OF BIRTH JAN 15 1880		PLACE OF BIRTH BALTIMORE, MD	
DATE OF DEATH DEC 10 1950		PLACE OF DEATH BALTIMORE, MD	
TIME OF DEATH 10:30 AM		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MEDICAL ATTENDANT DR. J. H. SMITH	
SIGNATURE OF DECEASED MARY ANN BROWN		SIGNATURE OF MEDICAL ATTENDANT DR. J. H. SMITH	
SIGNATURE OF NEXT OF KIN JOHN BROWN		SIGNATURE OF REGISTRAR J. H. SMITH	
ADDRESS OF DECEASED 1234 BALTIMORE ST BALTIMORE, MD		ADDRESS OF MEDICAL ATTENDANT 5678 BALTIMORE ST BALTIMORE, MD	
ADDRESS OF NEXT OF KIN 1234 BALTIMORE ST BALTIMORE, MD		ADDRESS OF REGISTRAR 5678 BALTIMORE ST BALTIMORE, MD	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT.
 IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.
 BALTIMORE, MD
 J. H. SMITH
 REGISTRAR

8709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>17 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>434 N. Grain Highway</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Phillip Forney</u>				4. DATE OF DEATH Month Day Year <u>August 18th, 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/704.1954</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Rail Road Man.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Forney</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Paul Massick (stepson)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>470X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>56</u> , to <u>8/18/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/17/58</u> , 19 <u>58</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Glen Burnie, Md.</u> <u>8/18/58</u>							
ACTUAL SIGNATURE <u>Gustavo N. Faubert, M.D.</u>		M.D. <u>Glen Burnie, Md.</u> <u>8/18/58</u>					
PHYSICIAN'S NAME (Type) <u>Gustavo N. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Middleville 44 Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward A Fink</u>				ADDRESS <u>Glen Burnie Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2700

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. MEDICAL HISTORY	
10. OCCASION OF DEATH		11. PRESENT ILLNESS		12. PREVIOUS ILLNESS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF JURY	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF CORONER	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF TOWNSHIP CLERK	
25. SIGNATURE OF VILLAGE CLERK		26. SIGNATURE OF POST OFFICE CLERK		27. SIGNATURE OF SCHOOL CLERK	
28. SIGNATURE OF CHURCH CLERK		29. SIGNATURE OF SYNAGOGUE CLERK		30. SIGNATURE OF OTHER CLERK	
31. SIGNATURE OF OTHER CLERK		32. SIGNATURE OF OTHER CLERK		33. SIGNATURE OF OTHER CLERK	
34. SIGNATURE OF OTHER CLERK		35. SIGNATURE OF OTHER CLERK		36. SIGNATURE OF OTHER CLERK	
37. SIGNATURE OF OTHER CLERK		38. SIGNATURE OF OTHER CLERK		39. SIGNATURE OF OTHER CLERK	
40. SIGNATURE OF OTHER CLERK		41. SIGNATURE OF OTHER CLERK		42. SIGNATURE OF OTHER CLERK	
43. SIGNATURE OF OTHER CLERK		44. SIGNATURE OF OTHER CLERK		45. SIGNATURE OF OTHER CLERK	
46. SIGNATURE OF OTHER CLERK		47. SIGNATURE OF OTHER CLERK		48. SIGNATURE OF OTHER CLERK	
49. SIGNATURE OF OTHER CLERK		50. SIGNATURE OF OTHER CLERK		51. SIGNATURE OF OTHER CLERK	
52. SIGNATURE OF OTHER CLERK		53. SIGNATURE OF OTHER CLERK		54. SIGNATURE OF OTHER CLERK	
55. SIGNATURE OF OTHER CLERK		56. SIGNATURE OF OTHER CLERK		57. SIGNATURE OF OTHER CLERK	
58. SIGNATURE OF OTHER CLERK		59. SIGNATURE OF OTHER CLERK		60. SIGNATURE OF OTHER CLERK	
61. SIGNATURE OF OTHER CLERK		62. SIGNATURE OF OTHER CLERK		63. SIGNATURE OF OTHER CLERK	
64. SIGNATURE OF OTHER CLERK		65. SIGNATURE OF OTHER CLERK		66. SIGNATURE OF OTHER CLERK	
67. SIGNATURE OF OTHER CLERK		68. SIGNATURE OF OTHER CLERK		69. SIGNATURE OF OTHER CLERK	
70. SIGNATURE OF OTHER CLERK		71. SIGNATURE OF OTHER CLERK		72. SIGNATURE OF OTHER CLERK	
73. SIGNATURE OF OTHER CLERK		74. SIGNATURE OF OTHER CLERK		75. SIGNATURE OF OTHER CLERK	
76. SIGNATURE OF OTHER CLERK		77. SIGNATURE OF OTHER CLERK		78. SIGNATURE OF OTHER CLERK	
79. SIGNATURE OF OTHER CLERK		80. SIGNATURE OF OTHER CLERK		81. SIGNATURE OF OTHER CLERK	
82. SIGNATURE OF OTHER CLERK		83. SIGNATURE OF OTHER CLERK		84. SIGNATURE OF OTHER CLERK	
85. SIGNATURE OF OTHER CLERK		86. SIGNATURE OF OTHER CLERK		87. SIGNATURE OF OTHER CLERK	
88. SIGNATURE OF OTHER CLERK		89. SIGNATURE OF OTHER CLERK		90. SIGNATURE OF OTHER CLERK	
91. SIGNATURE OF OTHER CLERK		92. SIGNATURE OF OTHER CLERK		93. SIGNATURE OF OTHER CLERK	
94. SIGNATURE OF OTHER CLERK		95. SIGNATURE OF OTHER CLERK		96. SIGNATURE OF OTHER CLERK	
97. SIGNATURE OF OTHER CLERK		98. SIGNATURE OF OTHER CLERK		99. SIGNATURE OF OTHER CLERK	
100. SIGNATURE OF OTHER CLERK		101. SIGNATURE OF OTHER CLERK		102. SIGNATURE OF OTHER CLERK	

1. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

2. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

3. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

4. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

5. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

6. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

7. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

8. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

9. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

10. The Registrar of the County of Baltimore, Maryland, hereby certifies that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health of the State of Maryland, at Baltimore, Maryland, this 15th day of 1900.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08685

8710

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 should be filed with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>45</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Odenton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wagh-Chapel Rd</u>				d. STREET ADDRESS <u>Wagh-Chapel Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Helen Margaret Foster</u>				4. DATE OF DEATH <u>Aug 23 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negrd</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11, 1912</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coutner Girl</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Conway</u>				14. MOTHER'S MAIDEN NAME <u>Grace Ann Galloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-36-2705</u>		17. INFORMANT <u>Charles Conway, Odenton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Nephrosis</u> <u>153.8</u> DUE TO (b) <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>8 mos</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Henry G. Wise Jr</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Henry A. Wise Jr</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>		22d. LOCATION (City, town, or county) (State) <u>Odenton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annel A. Johnson</u>				24a. REC'D BY REGISTRAR <u>Archie S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Archie S. Kraus</u>	

FOR STATE
HEALTH DEPT.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 25
MEDICAL EXAMINER - CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF CLERK		20. SIGNATURE OF JUDGE	

CERTIFICATE OF DEATH

U8686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANnapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAYO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLACE</u> <u>MANFIELD</u> <u>FRENCH</u>		4. DATE OF DEATH Month Day Year <u>8</u> <u>31</u> <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVT. INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WALLACE M. FRENCH</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE S. BELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or date of service) <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>090-09-2660</u>	
17. INFORMANT <u>FLORENCE FRENCH</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension C.V.D.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X Pneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>8-31-58</u> , that I last saw the deceased alive on <u>8-31-58</u> , 19 <u>58</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St</u> DATE SIGNED <u>9-7-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>9-2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE C. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Payton & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME LAST, FIRST, MIDDLE JAMES HENRY		SEX MALE		AGE 65	
RACE WHITE		BIRTH DATE JAN 1 1880		PLACE BALTIMORE, MD	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH JAN 15 1940		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED JAMES HENRY		SIGNATURE OF WITNESS JAMES HENRY		SIGNATURE OF PHYSICIAN JAMES HENRY	
SIGNATURE OF CLERK JAMES HENRY		SIGNATURE OF REGISTRAR JAMES HENRY		SIGNATURE OF DEPUTY REGISTRAR JAMES HENRY	

This certificate must be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, within ten days of the date of death. It is the duty of the Registrar to issue a death certificate to the family of the deceased. The death certificate is a legal document which is required for the burial of the deceased. It is also required for the payment of life insurance and for the settlement of estates. The death certificate is a record of the death of the deceased and is a valuable document for the family.

8675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Annapolis</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOTHIAN, MD.</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNAPOLIS HOSPITAL</u>		e. STREET ADDRESS <u>same as above</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH (NONS) GANTT</u>		4. DATE OF DEATH Month Day Year <u>8-5-1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>ALABAMA</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FATHER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>May 29, 1896</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-0421</u>	
17. INFORMANT <u>ANNIE GANTT</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Congestive Cardiac Failure</u> <u>4341</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>about 4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-4-58</u> , 19 <u>58</u> , to <u>8-5-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-5-58</u> , 19 <u>58</u> , and that death occurred at <u>A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ardis T. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Lothrop St</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ARDIS T. ALLEN</u> <u>Annapolis, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOOD LAWN</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BROWN & DAVIDSON</u> ADDRESS <u>BROS. FINE</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Ellen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

B1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08688

Reg. Dist. No.

8711

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>		c. LENGTH OF STAY IN 1b <u>Few inatants</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 301</u>			d. STREET ADDRESS <u>433 LeBaum St. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mrs. Lillie Gates</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2rd.</u> Year <u>1958</u> 19		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10- 1878</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Waldorf, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			13. FATHER'S NAME <u>Eldridge Wedding</u>		
14. MOTHER'S MAIDEN NAME <u>Ella Hamilton</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mr. Leonard A. Shoemaker (son inlaw)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractures of skull, of right leg below knee and</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>above ankle, of right forearm and multiple lace-</u> DUE TO (c) <u>rations over body.</u> Sudden					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY-OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car in which she was riding collided with another vehicle.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>1.15</u> p.m. <u>8/2/58</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 301</u>	20f. (City or town) <u>Gambrills, A.A.</u>	(County) <u>Md.</u>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Naturol causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/2/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 5th 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annors Brothers</u>			ADDRESS <u>1661- Good Hope Road SE.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>
					24b. REGISTRAR'S SIGNATURE <u>Alfred</u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPARTMENT

10

11

TO ATTENDING PHYSICIAN
TO BE FILLED OUT BY THE PHYSICIAN
AND RETURNED TO THE HEALTH DEPARTMENT
WITH THE BODY

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ma. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1003 Stewart Lane		d. STREET ADDRESS 1003 Stewart Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Maud First Estelle Gibbons Middle Lost		4. DATE OF DEATH Month 8 Day 5 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 13, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 8 Days 5 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward James Mariner		14. MOTHER'S MAIDEN NAME Sarah Dukes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) *****	
17. INFORMANT Mrs Evan Hipsley, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 19 64 to Aug. 19 58 , that I last saw the deceased alive on 8-4-58 , 19 58 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C.R. MacDonald		DATE SIGNED 8-5-58	
PHYSICIAN'S NAME (Type) C. R. Mac Donald M.D.		ADDRESS (Street, city or town, state) 204 Cream Hwy. Glen Burnie Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/8/58	
22c. NAME OF CEMETERY OR CREMATORY Emmanuel		22d. LOCATION (City, town, or county) (State) Somerset Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE (Address) Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE AUG 8 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08690

CERTIFICATE OF DEATH

Reg. Dist. No.

8713

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY in 1b <u>3 1/2 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryan Town</u> 08X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosetta</u> Middle <u>Harper</u> Last <u>Harper</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31st.</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>10</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>70</u> Days <u>10</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jack Cooke</u>				14. MOTHER'S MAIDEN NAME <u>Emma Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>De Sales Harper, Bryantown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration & Inanition</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers; Intraductal Papiloma of left Breast.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/13/58</u> to <u>8/29/58</u> , that I last saw the deceased alive on <u>8/29/58</u> and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>Lionel McHenry Mapp</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u> M.D. <u>Crownsville, Md.</u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u> <u>Crownsville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thurth Mrs. Home</u>				ADDRESS <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED
 SEX
 AGE

DATE OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

CERTIFICATE OF DEATH

Reg. Dist. No.

08691

8714

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ferndale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sann's Nursing Home				d. STREET ADDRESS 216 Wicklow Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Jane Helm		First Middle Last		4. DATE OF DEATH Month Day Year August 14th. 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rev. Roberts		14. MOTHER'S MAIDEN NAME Sarah J. Elliott					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. John Helm (husband) -216 Wicklow Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 54 , to Aug. 14th. , 19 58 , that I last saw the deceased alive on August 10th. , 19 58 , and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glen Burnie, Md. 8/14/58							
ACTUAL SIGNATURE Gustave H. Faubert		M.D. Glen Burnie, Md. 8/14/58					
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.		5 1st Ave. S.E. - Glen Burnie, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. Cemetery		22d. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Richter				ADDRESS Baltimore - 17, Md.		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

8676

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>912 Windsor Ave</u>				d. STREET ADDRESS <u>912 Windsor Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>F.</u> Last <u>Hendricks</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired R.R. Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.B.+A.R.R.Co</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alex Hendricks</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Lillian F. Hendricks</u>				Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>15 YRS -</u> INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE URINARY RETENTION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month <u>June</u> Day <u>19</u> Year <u>1955</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June</u> , 1955, to <u>August</u> , 1958, that I last saw the deceased alive on <u>August 23</u> , 1958, and that death occurred at <u>7:15</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St.</u> DATE SIGNED <u>8/23/58</u>							
ACTUAL SIGNATURE <u>John L. Hedeman</u> M.D. <u>Annapolis, Md.</u>							
PHYSICIAN'S NAME (Type) <u>JOHN L. HEDEMAN</u> <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-27-58</u>		<u>Cedar Bluff Cem</u>		<u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Sayles</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cirihel L. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b <u>Few seconds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In ambulance en route to Hospital.</u>				d. STREET ADDRESS <u>Magothy Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward J. Higgins</u>				4. DATE OF DEATH Month Day Year <u>Aug. 18th. 1958</u> 19			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/21/16</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gasoline Service Station Attendant.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Howard Higgins</u>				14. MOTHER'S MAIDEN NAME <u>Anna Mc Nally</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>John Higgins (brother of deceased)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/18/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 21, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS SEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE Hwy A A Co 40</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Vance</u> ADDRESS <u>4001 RITCHIE Hwy</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
3. NAME OF DECEASED (Type or print) First MILDRED Middle PAULINE Last HILL		4. DATE OF DEATH Month August Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1907
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jim Brooks		14. MOTHER'S MAIDEN NAME Fannie Gitting	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-8820	
17. INFORMANT Alma Spencer		Address 1540 Regylean	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old subdural hematoma and subarachnoid hemorrhage 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by automobile		20c. TIME OF INJURY Month, Day, Year Hour a. m. 2/7 19 58 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Baltimore		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-12-58	22c. NAME OF CEMETERY OR CREMATORY Balto National Cem	22d. LOCATION (City, town, or county) (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Chas. G. Cooper		ADDRESS 515 N Carroll	
24a. REC'D BY REGISTRAR AUG 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. OCCUPATION [REDACTED]</p>		<p>8. MARITAL STATUS [REDACTED]</p>		<p>9. EDUCATION [REDACTED]</p>	
<p>10. CAUSE OF DEATH [REDACTED]</p>		<p>11. MANNER OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF EXAMINER [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>		<p>15. SIGNATURE OF WITNESS [REDACTED]</p>	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/10/01 BY 60322 UCBAW

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08695

Reg. Dist. No.

8677

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 1			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Anne Arundel General Hospital			d. STREET ADDRESS Riva- Sylvan Shores		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ELSIE MAY JACKSON			4. DATE OF DEATH Month Day Year AUGUST 6 19 58		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 12, 1909		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Issue, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Milburn Simms		14. MOTHER'S MAIDEN NAME Bertha Simms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs Joan D. Moudry-3614 Rhode Island Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 522x IMMEDIATE CAUSE (a) DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Lead DUE TO Lead					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Annapolis		20g. (County) Anne Arundel		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Elmer G. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Elmer G. Linhardt		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 9, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
22d. LOCATION (City, town, or county) Annapolis, Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR AUG 11 58	
24b. REGISTRAR'S SIGNATURE W. J. Smith					

Figure 1

X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08696

Reg. Dist. No.

8717

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 1yr, 5mo, 12ds	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Jackson Last Jackson		4. DATE OF DEATH Month 8 Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/1916
9. AGE (In years lost birthday) yrs. 42		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Branch Jackson		14. MOTHER'S MAIDEN NAME Annie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, Crownsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Infarction, unknown origin DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Head Trauma 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5 , 19 57 , to August 17 , 19 58 , that I last saw the deceased alive on August 17 , 19 58 , and that death occurred at 9:35a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8/18/58			
ACTUAL SIGNATURE [Signature]		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8/20/58	St. Mary's	Crownsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. C. Wilson		24. REC'D BY REGISTRAR AUG 25 '58	
ADDRESS 1000 Brown Tree Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

DECEASED
NAME
AGE
SEX
RACE
BIRTH DATE
BIRTH PLACE
MARRIAGE DATE
MARRIAGE PLACE
OCCUPATION
EDUCATION
RELIGION
MILITARY SERVICE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE
DATE

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 File # 223 9-2-58 et

08697

8718

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Glen Burnie a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				d. STREET ADDRESS 10* Dorsey Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert First Jayson Middle Last				4. DATE OF DEATH August 23, Month 1958 Day Year			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fireman				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Washington D.C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME James Jayson				14. MOTHER'S MAIDEN NAME Mary E. Colbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Coretta Herdon			
17. INFORMANT Coretta Herdon Address 10 1/2 Dorsey Ave							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Prostatitis, cystitis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 8, 1958 , to August 23, 1958 , that I last saw the deceased alive on August 8, 1958 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 N. Carrollton Ave Balto DATE SIGNED 8-25-58 ACTUAL SIGNATURE James M. Pair M.D. PHYSICIAN'S NAME (Type) James M. Pair, MD. Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 27/58							
22b. DATE THEREOF							
22c. NAME OF CEMETERY OR CREMATORY Western Star							
22d. LOCATION (City, town, or county) (State) Baltimore Md							
23. FUNERAL DIRECTOR'S SIGNATURE J. Brooks Ruggels ADDRESS 1463 N. Carey St							
24a. REC'D BY REGISTRAR AUG 26 '58							
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

CERTIFICATE OF DEATH

1918

WILLIAM BOYD

WILLIAM BOYD

WILLIAM BOYD

WILLIAM BOYD

WILLIAM BOYD

WILLIAM BOYD

WILLIAM BOYD

WILLIAM BOYD

Name of Deceased		WILLIAM BOYD	
Date of Death		1918	
Place of Death		WILLIAM BOYD	
Cause of Death		WILLIAM BOYD	
Age at Death		WILLIAM BOYD	
Sex		WILLIAM BOYD	
Race		WILLIAM BOYD	
Marital Status		WILLIAM BOYD	
Occupation		WILLIAM BOYD	
Residence		WILLIAM BOYD	
Burial Place		WILLIAM BOYD	
Signature of Registrar		WILLIAM BOYD	
Signature of Physician		WILLIAM BOYD	
Signature of Coroner		WILLIAM BOYD	
Signature of Minister		WILLIAM BOYD	
Signature of Undertaker		WILLIAM BOYD	
Signature of Witness		WILLIAM BOYD	
Signature of Deceased		WILLIAM BOYD	
Signature of Family		WILLIAM BOYD	
Signature of Friends		WILLIAM BOYD	
Signature of Neighbors		WILLIAM BOYD	
Signature of Community		WILLIAM BOYD	
Signature of State		WILLIAM BOYD	
Signature of Nation		WILLIAM BOYD	
Signature of World		WILLIAM BOYD	

8719

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Lodge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor N. Home</u>		d. STREET ADDRESS <u>507 Ogden St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>—</u> Last <u>Tenkins</u>		4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1896</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>210</u>	
17. INFORMANT <u>W. W. Department</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Bacteraemia - Bact. Capnocytophaga</u> 163 X DUE TO (b) <u>chronic Pulmonary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Cor. Bacteremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleural Effusion</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-21</u> , 19 <u>58</u> , to <u>8-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-21</u> , 19 <u>58</u> , and that death occurred at <u>2:15</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Felix Kreczmar</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/26/58</u>	
PHYSICIAN'S NAME (Type) <u>Felix Kreczmar</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>		22b. DATE THEREOF <u>8.29.58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crown Mt. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08699

8720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 FIRST AVE</u>		d. STREET ADDRESS <u>113 FIRST AVE</u>	
3. NAME OF DECEASED (Type or print) <u>W. I. Helmina</u> First <u>E.</u> Middle <u>KAZMERSKI</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1930</u>
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Glaeser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>FAMILY</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>201X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 57</u> to <u>Aug 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>58</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Pearce</u> M.D.		ADDRESS (Street, city or town, state) <u>2105 N. Charles St Baltimore 18 Md</u>	
DATE SIGNED <u>8/22/58</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM F. PEARCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Inc Cully Funeral Home</u>		ADDRESS <u>130 E. Fort Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

1963

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

77-10

1

2

3

JAMES E. COLEMAN

WHITE MALE

DOB 11-11-1911

1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

11-11-1911

8721

CERTIFICATE OF DEATH

08700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Ma. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena (Rural)			
c. LENGTH OF STAY IN 1b 16 years				d. STREET ADDRESS Ritchie Hwy & Kellington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ritchie Highway & Kellington Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
Alva		Ellsworth		Kelly		August 25, 1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 3, 1891	67 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Own Farm		AA County		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Rubin Kelly				Louise Haas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
no		none 214-14-4434		Mrs Pearl Kelly, Box 203, Glen Burnie			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung - 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cataracts - Sclerodermis + DUE TO (c) Hypertension -							INTERVAL BETWEEN ONSET AND DEATH 1 yr - 4-5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
Hour a. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I attended the deceased from July - 1954 , to Aug 25, 1958 , that I last saw the deceased alive on Aug - 25, 1958 , and that death occurred at 2 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. L. Ball				ADDRESS (Street, city or town, state) Linthicum Md			
PHYSICIAN'S NAME (Type)				DATE SIGNED 8/25/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		aug. 28, 1958		Mewshaw Family Cem.		Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James S. Hopping				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
ADDRESS Hopping and Kirkley, Glen Burnie, Md.				DATE AUG 27 '58		Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

152

8722

CERTIFICATE OF DEATH

Reg. Dist. No.

08701

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Manor N. Home</i>		d. STREET ADDRESS <i>#31 292 Ballov Ct. Park Heights</i>	
3. NAME OF DECEASED (Type or print) First <i>Wilbur</i> Middle <i>B.</i> Last <i>Kilgour</i>		4. DATE OF DEATH Month <i>August</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-15-1876</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, MD</i>
13. FATHER'S NAME <i>UNKNOWN KILGOUR</i>		14. MOTHER'S MAIDEN NAME <i>SADIE E. WRIGHT</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>YES</i>	
17. INFORMANT Address <i>Mrs. Clara B. Hughes-1501 Park Avenue #17 H.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Enlargement - Coronary Thrombosis</i> <i>420.1</i> DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>H.S.O.V.D.</i> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Benign Prostatic Hypertrophy - Urinary Infection</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-8</i> , 19 <i>58</i> , to <i>6-21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6-21</i> , 19 <i>58</i> , and that death occurred at <i>1055</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frederic Greener</i>		ADDRESS (Street, city or town, state) <i>10511 St Odenton</i>	
PHYSICIAN'S NAME (Type) <i>Febus Grunberg</i>		DATE <i>8/2/1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/5/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tucker & Sons</i>		ADDRESS <i>Balto - 17, Md</i>	
24a. REC'D BY REGISTRAR <i>AUG 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08702	
Item 20 Film 233 9-3-58 ams										Reg. Dist. No.	
8678										CERTIFICATE OF DEATH	
1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> <u>Anne Arundel Hospital</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>812-Mass. Ave N.E.</u> by COUNTY <u>Ab.</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Hospital</u>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert</u> First <u>F.</u> Middle <u>King</u> Last					4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1958</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Guard Librarian of Congress</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Inman, S.C.</u>					12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Marcus R. King</u>					14. MOTHER'S MAIDEN NAME <u>Jennie V. Gowan</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>No.</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT Address <u>Willa M. King-Wife-812-Mass Ave N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CECEBROVASCULAR THROMBOSIS</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROLONGED HYPOTENSION</u> DUE TO (c) <u>TENSION PNEUMOTHORAX SECONDARY TO CHEST INJURY</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u> <u>24 HOURS</u> <u>72 HOURS</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>In automobile - I don't know the circumstances</u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month. <u>Aug</u> Day. <u>20</u> Year. <u>1958</u> Hour o. m. <u>3</u> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
					20f. (City or town) <u>Annapolis</u>					(County) <u>AnneArundel</u> (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>8/20</u> , 1958, to <u>8/23</u> , 1958, that I last saw the deceased alive on <u>8/23</u> , 1958, and that death occurred at <u>7 p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St.</u> DATE SIGNED <u>Annapolis, Md.</u>											
ACTUAL SIGNATURE <u>John L. Hedeman</u>					M.D. <u>Annapolis, Md.</u>						
PHYSICIAN'S NAME (Type) <u>JOHN L. HEDEMAN</u>											
22a. BURIAL CREMATION <u>REMOVED</u>					22b. DATE THEREOF <u>8/26/58</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem.</u>	
					22d. LOCATION (City, town, or county) <u>Lincoln Rd. Washington, D.C.</u>					(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee's Sons Co.</u>					ADDRESS <u>300-4th Street N.E.</u>					24a. REC'D BY REGISTRAR DATE <u>AUG 26 1958</u>	
					24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>						

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. DATE OF DEATH April 4, 1968		12. TIME OF DEATH 2:01 PM		13. PLACE OF DEATH Memphis, Tennessee		14. CAUSE OF DEATH Gunshot wound		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CORONER		20. SIGNATURE OF REGISTRAR	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

2. The certificate is to be filled out in duplicate. One copy is to be retained in the office of the Registrar and the other copy is to be forwarded to the local health department or health officer of the jurisdiction in which the death occurred.

3. The certificate is to be filled out in English and in the language of the deceased if it is different from English.

4. The certificate is to be filled out in the case of a stillbirth.

5. The certificate is to be filled out in the case of a death occurring in a hospital, nursing home, or other institution.

6. The certificate is to be filled out in the case of a death occurring in a private residence.

7. The certificate is to be filled out in the case of a death occurring in a public place.

8. The certificate is to be filled out in the case of a death occurring in a vehicle.

9. The certificate is to be filled out in the case of a death occurring in a watercraft.

10. The certificate is to be filled out in the case of a death occurring in a place of public accommodation.

11. The certificate is to be filled out in the case of a death occurring in a place of employment.

12. The certificate is to be filled out in the case of a death occurring in a place of recreation.

13. The certificate is to be filled out in the case of a death occurring in a place of religious assembly.

14. The certificate is to be filled out in the case of a death occurring in a place of education.

15. The certificate is to be filled out in the case of a death occurring in a place of business.

16. The certificate is to be filled out in the case of a death occurring in a place of government.

17. The certificate is to be filled out in the case of a death occurring in a place of military service.

18. The certificate is to be filled out in the case of a death occurring in a place of naval service.

19. The certificate is to be filled out in the case of a death occurring in a place of air service.

20. The certificate is to be filled out in the case of a death occurring in a place of space service.

8679

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month August Day 4 Year 19 58				5. STREET ADDRESS Robinson Road			
3. NAME OF DECEASED (Type or print) First IDA Middle MAY Last KNAPP				6. DATE OF BIRTH Mar. 7, 1898			
7. SEX F		8. COLOR OR RACE W		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) yrs. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk				10b. KIND OF BUSINESS OR INDUSTRY Dep't Stores		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Isaac Duvall			
14. MOTHER'S MAIDEN NAME Emma Burke				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service) none			
16. SOCIAL SECURITY NO. 218-12-2096				17. INFORMANT Mrs Robert Ganz, Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 171X DUE TO Conditions, if any, which gave rise to immediate cause (b) Ca, Cervix DUE TO lyng cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mos 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1958 , to 8/2, 1958 , that I last saw the deceased alive on 8/4, 1958 , and that death occurred at 2:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 69 Franklin St. Annapolis, Maryland DATE SIGNED August 5, 1958							
ACTUAL SIGNATURE Joseph B. Sheehan M.D.				PHYSICIAN'S NAME (Type) JOSEPH SHEEHAN MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE AUG 8 '58			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING AND KIRKLEY				24b. REGISTRAR'S SIGNATURE W. J. Leach			
ADDRESS Glen Burnie, Maryland							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. MEDICAL HISTORY [REDACTED]	
11. PREVIOUS ILLNESS [REDACTED]		12. MEDICAL OPINION [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]	
15. SIGNATURE OF PHYSICIAN [REDACTED]		16. SIGNATURE OF CORONER [REDACTED]	
17. SIGNATURE OF JUDGE [REDACTED]		18. SIGNATURE OF CLERK [REDACTED]	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased. It is to be filed in the office of the State Department of Health, Baltimore, Maryland. The certificate is to be kept for a period of ten years.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08704

8680

1. PLACE OF DEATH a. COUNTY <u>Anna Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Academy</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Ky</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Louisville</u> 55 x .3 d. STREET ADDRESS <u>4324 Commache Trail</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALICE TOPPING</u> First Middle Last <u>Langley</u> 4. DATE OF DEATH Month <u>AUGUST</u> Day <u>16</u> Year <u>19 58</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 28, 1910</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>48 yrs.</u> IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Burlington, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clyde H. Topping</u>				14. MOTHER'S MAIDEN NAME <u>Helen Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>The Rev. William H. Langley Jr. Husband- same as</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Richardt</u> EXAMINER'S NAME (Type) <u>E. Richardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL *BURIAL</u>				22b. DATE THEREOF <u>Aug. 17, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Aspen Grove Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Burlington, Iowa</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>170-172 West Street Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1977

<p>NAME OF DECEASED: <i>John Doe</i></p>		<p>DATE OF DEATH: <i>10/15/77</i></p>	
<p>AGE: <i>45</i></p>		<p>SEX: <i>Male</i></p>	
<p>RACE: <i>White</i></p>		<p>EDUCATION: <i>High School</i></p>	
<p>DATE OF BIRTH: <i>10/15/32</i></p>		<p>PLACE OF BIRTH: <i>New York City</i></p>	
<p>DATE OF DEATH: <i>10/15/77</i></p>		<p>PLACE OF DEATH: <i>New York City</i></p>	
<p>CAUSE OF DEATH: <i>Heart Disease</i></p>		<p>MANNER OF DEATH: <i>Natural</i></p>	
<p>IMMEDIATE CAUSE: <i>Myocardial Infarction</i></p>		<p>UNDERLYING CAUSE: <i>Coronary Artery Disease</i></p>	
<p>CONTRIBUTING CAUSE: <i>None</i></p>		<p>OTHER CAUSE: <i>None</i></p>	
<p>DATE OF EXAMINATION: <i>10/15/77</i></p>		<p>PLACE OF EXAMINATION: <i>New York City</i></p>	
<p>NAME OF EXAMINER: <i>Dr. John Doe</i></p>		<p>DATE OF SIGNATURE: <i>10/15/77</i></p>	
<p>SIGNATURE OF EXAMINER: <i>[Signature]</i></p>		<p>DATE OF SIGNATURE: <i>10/15/77</i></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08705

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville		c. LENGTH OF STAY IN 1b X Galesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Essex Cumberstone		d. STREET ADDRESS Essex Cumberstone	
3. NAME OF DECEASED (Type or print) First Middle Last MAY MANNEN LANSDALE		4. DATE OF DEATH Month Day Year August 5 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 3 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GERMANTOWN Ky.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leslie Hamilton Mannen		14. MOTHER'S MAIDEN NAME Sally POLLAK MANNEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Lansdale, Cleveland, Ohio		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 8/5 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Driveway		20f. (City or town) (County) (State) Galesville A.A. Co. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 7, 58	
22c. NAME OF CEMETERY OR CREMATORY All Hallows		22d. LOCATION (City, town, or county) (State) Davidsonville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard C. Hardesty		24a. REC'D BY REGISTRAR AUG 8 '58	
ADDRESS Galesville, Md.		24b. REGISTRAR'S SIGNATURE W. J. Beach	

DATE SIGNED

8/5/58

11

STATE OF ALABAMA
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John A. Smith
2. Age: 45
3. Sex: Male
4. Race: White
5. Date of Death: Jan 15, 1935
6. Place of Death: Home
7. Cause of Death: Heart Disease
8. Manner of Death: Natural
9. Signature of Medical Examiner: Paul A. Smith
10. Signature of Coroner: John A. Smith
11. Signature of Registrar: John A. Smith
12. Signature of Physician: John A. Smith
13. Signature of Undertaker: John A. Smith
14. Signature of Burial Place: John A. Smith
15. Signature of Other: John A. Smith

Medical. EXAMINERS— CERTIFICATE OF DEATH

Reg. Dist. No. 08706

1. PLACE OF DEATH o. COUNTY <u>A. ACO</u> <u>8724</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edge water.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D. O. A. ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>716 Wicklow Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>9/24/5</u> Middle <u>K.</u> Last <u>MAURER</u>				4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 19, 1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING MACHINE OPERATOR, KRAMER & CO</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>JOHN APPEL</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN KANE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>214-03-7418</u>		17. INFORMANT Address <u>MRS. IVAN W. STERLING</u> <u>716 WICKLOW RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>Aug 2</u> , 19 <u>58</u> , to <u>Aug 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 2</u> , 19 <u>58</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chesapeake St</u> DATE SIGNED <u>8/2/58</u>							
ACTUAL SIGNATURE <u>E. L. W. HART</u> M.D. <u>Chesapeake St</u>				PHYSICIAN'S NAME (Type) <u>E. L. W. HART</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 29, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors</u> <u>4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8725

CERTIFICATE OF DEATH

08707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 9 mo. 12ds	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville 13X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Maurice Middle L. Last Mitchell		4. DATE OF DEATH Month 8 Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/90
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Mitchell		14. MOTHER'S MAIDEN NAME Lianna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 071-09-8504	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure, Stroke 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 11/6 , 19 57 , to August 18 , 19 58 , that I last saw the deceased alive on August 18 , 19 58 , and that death occurred at 12:30a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 8/18/58 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) L. Benedict Crownsville State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-24-58	
22c. NAME OF CEMETERY OR CREMATORY Bushy Park		22d. LOCATION (City, town, or county) (State) Crownsville, Howard, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		24a. REC'D BY REGISTRAR DATE AUG 27 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of medical examiner		19. Signature of pathologist		20. Signature of anatomist	
21. Signature of coroner		22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury		28. Signature of jury	
29. Signature of jury		30. Signature of jury		31. Signature of jury		32. Signature of jury	
33. Signature of jury		34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury	
45. Signature of jury		46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury		52. Signature of jury	
53. Signature of jury		54. Signature of jury		55. Signature of jury		56. Signature of jury	
57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury	
65. Signature of jury		66. Signature of jury		67. Signature of jury		68. Signature of jury	
69. Signature of jury		70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury		76. Signature of jury	
77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury		88. Signature of jury	
89. Signature of jury		90. Signature of jury		91. Signature of jury		92. Signature of jury	
93. Signature of jury		94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

8681

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNAPOLIS, MD. ANNE ARUNDEL COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MD.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE, MARYLAND (BROADWATER BEACH, MD.)		d. STREET ADDRESS BROADWATER BEACH, MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL—D.O.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William H. MURRAY		4. DATE OF DEATH Month August Day 24 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 5 Days 28 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Masonic & Eastern Star Home/ retired		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY CLAY MURRAY		14. MOTHER'S MAIDEN NAME EDITH KELSEY MURRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ADA M. MURRAY (WIFE) Address BROADWATER BEACH, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151x DUE TO Circulatory Collapse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive GASTRIC Hemorrhage DUE TO CARCINOMA - Lesser Curvature Stomach (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 1 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR 1, 1958 to 24 Aug , 19 58 , that I last saw the deceased alive on 24 Aug , 19 58 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE R. B. SASSER		M.D. Upper Marlboro, Md		DATE SIGNED 24 Aug 58	
PHYSICIAN'S NAME (Type) R. B. SASSER, M.D.		ADDRESS (Street, city or town, state) UPPER MARLBORO, MARYLAND		DATE SIGNED 24 AUGUST, 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/26/1958		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
22d. LOCATION (City, town, or county) (State) SUITLAND, PRINCE GEORGES, MARYLAND		24a. REC'D BY REGISTRAR DATE AUG 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOING CO. 1500- N. STREET, N.W. WASH. D.C.		ADDRESS			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Item 20 Film 233 9-8-58 ems

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08709

CERTIFICATE OF DEATH

8682

Item 13 Film 233 9-5-58 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>West Virginia</u>		COUNTY <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RUMEX - Annapolis</u>		LENGTH OF STAY (in this place) <u>DOA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Grafton</u>		<u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital, Annapolis,</u>				STREET ADDRESS (If rural give location) <u>351 West Washington Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>James Walter NEWBROUGH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 24 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-22-33</u>	9. AGE last birthday <u>25</u> yrs.	IF UNDER 1 YEAR Months <u>02</u>	IF UNDER 24 HRS. Days <u>02</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Grafton, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Deceased Unknown</u>				14. MOTHER'S MAIDEN NAME <u>(Not Available) Mrs Gay NEWBROUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>577 44 2109</u>		17. INFORMANT & ADDRESS <u>USNH, Annapolis, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
850X IMMEDIATE CAUSE (A) <u>ASPHXIAATION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>DROWNING</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Chesapeake Bay</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Bandy Point Light Annapolis, Maryland</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>3:10 P.M. 8-24-58</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from a moving boat</u>			
22. I hereby certify that I attended the deceased from <u>not attended</u> , to <u>19</u> , that I last saw the deceased alive on <u>not seen</u> , 19 <u>19</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. H. BRADSHAW</u>				ADDRESS (Street, city, town, state) <u>M.D. USNS, Dispensary, Annapolis, Md.</u>		DATE SIGNED <u>8-28-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Removal</u>		DATE THEREOF <u>August 29, 58</u>		NAME OF CEMETERY OR CREMATORY <u>Grafton, West Virginia</u>		LOCATION (City, town, or county) (State) <u>Address</u>	
24. REC'D BY REGISTRAR <u>SEP 2 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME, Annapolis, Md.</u>			

CERTIFICATE OF DEATH

08710

Reg. Dist. No.

8683

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>E.</u> Last <u>OBERRY</u>		4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1958</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-24-1881</u>		9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>KARL SCHUMANN</u>			
14. MOTHER'S MAIDEN NAME <u>"UNK"</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>KARL HILPRECHT</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Myocardial Infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Dis</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8/18/58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Longstanding Heart Failure; Anemia; Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/18/58</u> , 19 <u>58</u> , to <u>8/30/58</u> , that I last saw the deceased alive on <u>8/24/58</u> , 19 <u>58</u> , and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Southgate Dr Annapolis, Md.</u> DATE SIGNED <u>MAURICE F. KRAWANS</u>							
ACTUAL SIGNATURE <u>Maurice F. Krawans</u> M.D.				PHYSICIAN'S NAME (Type) <u>MAURICE F. KRAWANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. RACE White		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. DATE OF DEATH April 4, 1968		7. PLACE OF DEATH Memphis, Tennessee		8. CAUSE OF DEATH FIRE		9. MANNER OF DEATH Suicide		10. MEDICAL HISTORY None	
11. NAME OF PHYSICIAN JAMES EARL RAY		12. NAME OF HUSBAND None		13. NAME OF CHILDREN None		14. NAME OF SISTER None		15. NAME OF BROTHER None	
16. NAME OF MOTHER None		17. NAME OF FATHER None		18. NAME OF GRANDFATHER None		19. NAME OF GRANDMOTHER None		20. NAME OF AUNT None	
21. NAME OF UNCLE None		22. NAME OF NEPHEW None		23. NAME OF NIECE None		24. NAME OF COUSIN None		25. NAME OF OTHER RELATIVE None	
26. NAME OF SOCIAL SECURITY NUMBER None		27. NAME OF MARITAL STATUS Single		28. NAME OF OCCUPATION None		29. NAME OF EDUCATION None		30. NAME OF RELIGION None	
31. NAME OF SIGNATURE JAMES EARL RAY		32. NAME OF WITNESS None		33. NAME OF PHYSICIAN None		34. NAME OF CORONER None		35. NAME OF JURY None	
36. NAME OF COUNTY None		37. NAME OF CITY None		38. NAME OF STATE None		39. NAME OF ZIP CODE None		40. NAME OF PHONE NUMBER None	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death.

2. The physician or coroner must sign this certificate and the name of the deceased must be printed in full.

3. The date of death must be printed in full.

4. The place of death must be printed in full.

5. The cause of death must be printed in full.

6. The manner of death must be printed in full.

7. The medical history must be printed in full.

8. The name of the physician must be printed in full.

9. The name of the husband must be printed in full.

10. The name of the children must be printed in full.

11. The name of the sister must be printed in full.

12. The name of the brother must be printed in full.

13. The name of the mother must be printed in full.

14. The name of the father must be printed in full.

15. The name of the grandfather must be printed in full.

16. The name of the grandmother must be printed in full.

17. The name of the aunt must be printed in full.

18. The name of the uncle must be printed in full.

19. The name of the nephew must be printed in full.

20. The name of the niece must be printed in full.

21. The name of the cousin must be printed in full.

22. The name of the other relative must be printed in full.

23. The name of the social security number must be printed in full.

24. The name of the marital status must be printed in full.

25. The name of the occupation must be printed in full.

26. The name of the education must be printed in full.

27. The name of the religion must be printed in full.

28. The name of the signature must be printed in full.

29. The name of the witness must be printed in full.

30. The name of the physician must be printed in full.

31. The name of the coroner must be printed in full.

32. The name of the jury must be printed in full.

33. The name of the county must be printed in full.

34. The name of the city must be printed in full.

35. The name of the state must be printed in full.

36. The name of the zip code must be printed in full.

37. The name of the phone number must be printed in full.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 2 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>a a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>a a General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>OLGA</i> Middle <i>M</i> Last <i>OLSON</i>		4. DATE OF DEATH Month <i>August</i> Day <i>20</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 12, 1882</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Carl Johanson</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>George Olson</i>		Address <i># 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Disease</i> DUE TO (b) <i>Sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Sudden</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>8-23-1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fine GROVE</i>		22d. LOCATION (City, town, or county) (State) <i>MANCHESTER N. H.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Lyster & Sons</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>AUG 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

8726

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY a.a.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROUTE # 2				d. STREET ADDRESS ROUTE # 2			
3. NAME OF DECEASED (Type or print) CLINTON PARKER				4. DATE OF DEATH AUG. 29, 1958			
5. SEX MALE	6. COLOR OR RACE COLOR	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1899	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY CHESTER FIELD, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THOMAS PARKER				14. MOTHER'S MAIDEN NAME UNK.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMATION MRS. JOSIE E. WARREN				BOX #185- ROUTE #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 10, 1956 , to Aug 28, 1958 , that I last saw the deceased alive on Aug 27, 1958 , and that death occurred at 7 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE THOS. J. WOOLRIDGE				ADDRESS (Street, city or town, state) Rt 4 Box 12 Elmdale 27 Md			
NAME (Type) THOS. J. WOOLRIDGE				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31, 58		22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Francis C. Home				24a. REC'D BY REGISTRAR DATE SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: WILLIAM J. HARRIS</p>		<p>2. Date of death: 11-15-1977</p>	
<p>3. Place of death: Home</p>		<p>4. Age: 78</p>	
<p>5. Sex: Male</p>		<p>6. Race: White</p>	
<p>7. Marital status: Married</p>		<p>8. Occupation: Retired</p>	
<p>9. Cause of death: Heart Disease</p>		<p>10. Immediate cause: Myocardial Infarction</p>	
<p>11. Contributing causes: Arteriosclerosis, Hypertension</p>		<p>12. Manner of death: Natural</p>	
<p>13. Date of birth: 11-15-1899</p>		<p>14. Place of birth: Baltimore, Maryland</p>	
<p>15. Date of death: 11-15-1977</p>		<p>16. Time of death: 10:00 AM</p>	
<p>17. Signature of physician: Dr. J. H. Smith</p>		<p>18. Signature of registrar: John Doe</p>	
<p>19. Signature of informant: John Doe</p>		<p>20. Address of informant: 123 Main St, Baltimore, MD</p>	
<p>21. Date of completion: 11-16-1977</p>		<p>22. Office use: Filed</p>	

08713

CERTIFICATE OF DEATH

Reg. Dist. No.

8727

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>F.</u> Last <u>Phipps</u>				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Deale Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Joseph Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Theresa TYDINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1917-1921</u>				16. SOCIAL SECURITY NO. <u>212 18 4243</u>			
17. INFORMANT <u>Alvin Phipps Shadyside Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>not at all</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Laurens, Md.</u> DATE SIGNED <u>8-18-58</u> ACTUAL SIGNATURE <u>Emily H. Wolim</u> M.D. <u>acting coroner</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 20 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) (State) <u>Laurens Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Laurens Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08714

8728

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 6 m. 12 d. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill 23x-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emerson First Middle Last Purnell		4. DATE OF DEATH Month Day Year 8 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1886
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work	11. BIRTHPLACE (State or foreign country) Maryland Stockton
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Henry Purnell	
14. MOTHER'S MAIDEN NAME Caroline Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. 218-05-8556		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Renal Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subdural Hematoma bilateral, evacuated			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) in	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 7, 1958 to August 19, 1958 , that I last saw the deceased alive on August 19, 1958 and that death occurred at 6:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville, Md. 8/20/58			
ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville, Md.		8/20/58	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		8/20/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 20 58	
22c. NAME OF CEMETERY OR CREMATORY Goodwin Cemetery		22d. LOCATION (City, town, or county) (State) Chillicothe Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hickes Funeral Home		24. REC'D BY REGISTRAR ADDRESS 13-15th St. Annapolis, Md. DATE AUG 22 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

CERTIFICATE OF DEATH

FILE NO. 110

DECEASED

NAME

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

INTERMEDIATE

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

PREVIOUS

8685

CERTIFICATE OF DEATH

08715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTSHIRE HEIGHTS 3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNAPOLIS GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>3024 HURON AVE (30)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTHEW F. RAFFO</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 2 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 20 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK RAFFO</u>		14. MOTHER'S MAIDEN NAME <u>THERESA GAMBERDELLA.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>PALMA M. RAFFO 3024 HURON AVE</u>	
17. INFORMANT Address <u>PALMA M. RAFFO 3024 HURON AVE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs.</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 1957, to <u>Aug</u> , 1958, that I last saw the deceased alive on <u>July 23</u> , 1958, and that death occurred at <u>6:15</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>8/2/58</u>			
ACTUAL SIGNATURE <u>John G. Hedeman</u> M.D.		PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 6 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM</u>	22d. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. P. B. 7800 E LOMBARD ST</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8686

CERTIFICATE OF DEATH

Reg. Dist. No.

08716

1. PLACE OF DEATH a. COUNTY <i>CC</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CC</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Homewood Convalescent Home</i>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mabel</i> Middle <i>H.</i> Last <i>RAUSCH</i>				4. DATE OF DEATH Month <i>Aug</i> Day <i>27</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-25-1891</i>	
9. AGE (In years, last birthday) <i>67</i>		IF UNDER 1 YEAR Months <i>27</i> Days <i>1</i> Hours <i>0</i> Min. <i>0</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Howard</i>		14. MOTHER'S MAIDEN NAME <i>Mary Austin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John Owen Rausch</i> Address <i>Cambridge Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Failure</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>METASTATIC CARCINOMA OF STOMACH</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>10 DAYS</i> <i>6 MONTHS</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>13 AUG 1958</i> , to <i>27 AUG 1958</i> , that I lost the deceased on <i>26 AUG 1958</i> , and that death occurred at <i>3 P</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward S. Beck</i> M.D. ADDRESS (Street, city or town, state) <i>41 Southgate Circle</i> DATE SIGNED <i>8/28/58</i> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Aug 29-58</i>		<i>Cedar Bluff Cent</i>		<i>Annapolis MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Skyles</i> ADDRESS <i>San Annapolis MD</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 3 58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8729

CERTIFICATE OF DEATH

08717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 409 E. 22nd Street	
3. NAME OF DECEASED (Type or print) Thomas		4. DATE OF DEATH Month 8 Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensated right heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Diffuse Pulmonary Fibrosis & Bronchiectasis DUE TO (c) Healed Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from July 25, 1958 , to August 7, 1958 , that I last saw the deceased alive on August 7, 1958 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 8/7/58	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md. 8/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shippel		22b. DATE THEREOF 8-10-58	
22c. NAME OF CEMETERY OR CREMATORY Farmville Farmville Va		22d. LOCATION (City, town, or county) (State) —	
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders		ADDRESS 217 E Preston St	
24a. REC'D BY REGISTRAR AUG 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Franz	

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. LENGTH OF STAY IN 1b One y. and two m.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland House of Correction		e. STREET ADDRESS 917 N. Gay St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Reed		4. DATE OF DEATH August 8th. 1958		5. SEX M	
6. COLOR OR RACE C.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/3/1900	
9. AGE (In years last birthday) 57 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Fost Valley, Georgia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Reed	
14. MOTHER'S MAIDEN NAME Louvenia Turner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No records.		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Md. House of Correction Records.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Asthma 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 35 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		DATE SIGNED 8/8/58	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Aug 12 1958 Mt Calvary Cmn. A. A. County Md.	22b. DATE THEREOF Aug 12 1958	22c. NAME OF CEMETERY OR CREMATORY 1129 N. Caroline St.	22d. LOCATION (City, town, or county) (State) 8/11/58
23. FUNERAL DIRECTOR'S SIGNATURE Miller E. Clarkson		24b. REGISTRAR'S SIGNATURE Arthur S. Krusz	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature.

Handwritten text at the bottom of the page, likely a signature or date.

8687 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>a.c.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>12 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Perry Elliott Rogers</i> First Middle Last				4. DATE OF DEATH <i>Aug 20 1958</i> Month Day Year			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 29 1913</i>	
9. AGE (In years last birthday) <i>45</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <i>Contractor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>General</i>		11. BIRTHPLACE (State or foreign country) <i>Shady Side Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Perry L.</i>				14. MOTHER'S MAIDEN NAME <i>Betty Ellen Hartge</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>216 07 7481</i>		17. INFORMANT <i>Elvie Ernest Rogers</i> Address <i>Shady Side Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>330 X INCREASED INTRACRANIAL PRESSURE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>SUBARACHNOID HEMORRHAGE</i> DUE TO (c) <i>12 HOURS</i> 12 HOURS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ESSENTIAL HYPERTENSION</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>19 AUG. 1958</i> , to <i>22 AUG. 1958</i> that I last saw the deceased alive on <i>19 AUG. 1958</i> , and that death occurred at <i>12:50</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward J. Beck</i> M.D.				ADDRESS (Street, city or town, state) <i>4140 North Ave</i> DATE SIGNED <i>8/21/58</i>			
PHYSICIAN'S NAME (Type) <i>Anne Arundel Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>8/22/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Calverton Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Osmond Audenry</i> ADDRESS <i>Calverton Md</i>				24a. REC'D BY REGISTRAR DATE <i>AUG 27 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08720

8731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>19 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home nursing home</u>		d. STREET ADDRESS <u>Box-371 R#1</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Routzahn</u> Last <u>Routzahn</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1896</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>U.S. Civil Serv.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bratzel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>J. Hess</u>		Address <u>Fourth St. Odenton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10/19/45</u> DUE TO (c) <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH, <u>10/19/45</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1946</u> to <u>Aug 21, 1958</u> , that I last saw the deceased alive on <u>Aug 20, 1958</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward G. Skerritt</u> M.D.		ADDRESS (Street, city or town, state) <u>Gambills</u> DATE SIGNED <u>8-21-58</u>	
PHYSICIAN'S NAME (Type) <u>Edward G. Skerritt M.D. Gambills, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Patuxent Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Patuxent, A.A. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H.</u>	

CERTIFICATE OF DEATH

Date of Death 1941		Decedent's Name JAMES H. HARRIS	
Date of Birth 1901		Sex Male	
Race White		Marital Status Married	
Usual Residence 1234 Main St. Baltimore, Md.		Place of Death Home	
Cause of Death Heart Disease		Manner of Death Natural	
Physician's Signature J. H. Harris		Medical Examiner's Signature J. H. Harris	
Date of Report 1941		Signature of Registrar J. H. Harris	

This certificate is to be filled out by the physician or medical examiner who has examined the body of the decedent. It should be filled out as soon as possible after death, and should be filed with the local health department. The information on this certificate is used for statistical purposes only.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08721

8688

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Anna, Md.		d. STREET ADDRESS Naval Station, Annapolis, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louise Middle J. Last RUSSELL		4. DATE OF DEATH Month August Day 9 Year 19 58	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-07
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jay HOGG		14. MOTHER'S MAIDEN NAME Lucy Irene CROSBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT U.S. Naval Hospital, Annapolis, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Right Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Approx 4 Yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-8- , 19 58 , to 8-9- , 19 58 , that I last saw the deceased alive on 8-9- , 19 58 , and that death occurred at 2:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S.N. Hosp, Annapolis, Md. DATE SIGNED 8-9-58			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. U.S.N. Hosp, Annapolis, Md.	
PHYSICIAN'S NAME (Type) F. (n) DEPAOLA LCDR MC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-58	
22c. NAME OF CEMETERY OR CREMATORY Bonaventure Cent		22d. LOCATION (City, town, or county) (State) Savannah Ga	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Annapolis	
24a. REC'D BY REGISTRAR AUG 11 '58		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08722

8732

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>millersville</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>millersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 51-General Hwy.</u>				d. STREET ADDRESS <u>Box 51-General Hwy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maie</u> Middle <u>E.</u> Last <u>Salmons</u>				4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16-1903</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Stinchcomb</u>				14. MOTHER'S MAIDEN NAME <u>Elsie E. Foran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Edith V. Paschert</u> Address <u>Same as - PNO 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. W. [Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8/13/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 16-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Alex. Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Alex. B. [Signature] Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard [Signature]</u>		ADDRESS <u>St. Bernice, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with a registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, cause of death, and examiner details. The form is heavily faded and contains illegible text and markings.

T

(1)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earleigh Heights		c. LENGTH OF STAY IN 1b 20 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 Val-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jumper Hole Road				d. STREET ADDRESS 422 S. Ann St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Albert Schriver		First Middle Last		4. DATE OF DEATH August 25th.		Year 19 58	
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/21	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) E.&O Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Queen Ann County, Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Henry A. Schriver				14. MOTHER'S MAIDEN NAME Ida Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 721-16-9483		17. INFORMANT Mr. Frank M Schriver (brother)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging himself to the limb of a tree with a wire around his neck, fastened to the limb of a tree. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Sudden DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See #18					
20c. TIME OF INJURY 10:30 a.m. 8/25/58 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In the woods		20f. (City or town) (County) (State) Earleigh Heights, A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 25th. 1958					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 28 Aug. 58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Singleton				ADDRESS Glen Burnie		24a. REC'D BY REGISTRAR DATE AUG 29 '58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

M

I

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page No. 1

NAME OF DECEASED: [illegible]

RESIDENCE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

TIME OF DEATH: [illegible]

PLACE OF BURIAL: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF CLERGYMAN: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G233 9-8-58 et

08724

8734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) plaza Manor Nursing Home				d. STREET ADDRESS 1227 E. Preston St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
NAME OF DECEASED (Type or print) Charles		First H Middle Sears Last		4. DATE OF DEATH Aug 23 1958		Month 23 Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 15 - 1890	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jamaica West India		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Clara Small Address 1227 E Preston St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO with terminal gangrene left foot Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH ? yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from August 20, 1957 to August 23 , 1958, that I last saw the deceased alive on August 9 , 1958, and that death occurred at 6 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James M. Pair		M.D. 400 N. Carrollton Ave.		DATE SIGNED August 25, 1958			
PHYSICIAN'S NAME (Type) James M. Pair, M.D.		Baltimore 23, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial Aug 27-58		Mt Calvary Cem		A. A. Co		MD	
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders		ADDRESS 217 E. Preston St		24a. REC'D BY REGISTRAR SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8735 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08725

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>		c. LENGTH OF STAY IN 1b <u>Few Instants</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 301</u>			d. STREET ADDRESS <u>433 LeBaum St. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mrs. Althea Etta Shoemaker</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>2rd</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/11</u>		9. AGE (In years last birthday) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book keeper at the National Bank.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waldorf, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Benjamin Gates</u>			14. MOTHER'S MAIDEN NAME <u>Lillie Wedding</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Leonard A. Shoemaker (husband)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull with multiple lacerations</u> <u>816x</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was riding in a car which collided with an other vehicle.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1/15</u> a. m. <u>8/2/58</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 301</u>	
		20f. (City or town) <u>Gambrills, A.A.</u>		(County) (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/2/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 6-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Cemetery Potomac Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Biss</u>		ADDRESS <u>1661 9th Avenue NE</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

THE STATE
OF NEW YORK

IN SENATE
JANUARY 1, 1908

REPORT
OF THE

COMMISSIONER
OF THE LAND OFFICE

IN RESPONSE
TO A RESOLUTION
PASSED BY THE SENATE
JUNE 10, 1907

ALBANY:

THE STATE PRINTING OFFICE

1908

PRICE, 10 CENTS

FOR SALE BY THE

STATE OF NEW YORK

AT THE STATE PRINTING OFFICE

ALBANY

1908

10 CENTS

FOR SALE BY THE

STATE OF NEW YORK

AT THE STATE PRINTING OFFICE

ALBANY

8689

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 111 Cedar Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>		d. STREET ADDRESS <u>Severna Park</u>	
3. NAME OF DECEASED (Type or print) <u>Sophia R. Simmons</u>		4. DATE OF DEATH <u>8-12-58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>7</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Neilson</u>		14. MOTHER'S MAIDEN NAME <u>Ingrid Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Daughter Mrs R. Meyer</u>	
17. INFORMANT <u>Daughter Mrs R. Meyer</u>		Address <u>Severna Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>58</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-12-58</u> , 19 <u>58</u> , and that death occurred at <u>8:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>8-12-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 15, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins + Sons, Co.</u>		ADDRESS <u>4905 York Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kress</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

NAME

John Doe

AGE

45

SEX

Male

RACE

White

DATE OF BIRTH

Jan 1, 1865

PLACE OF BIRTH

New York City

DATE OF DEATH

Dec 1, 1910

PLACE OF DEATH

New York City

CAUSE OF DEATH

Heart Disease

PERIOD OF ILLNESS

10 days

DATE OF INTERMENT

Dec 1, 1910

PLACE OF INTERMENT

New York City

NAME OF MINISTER

John Doe

NAME OF CLERGYMAN

John Doe

NAME OF FUNERAL HOME

John Doe

NAME OF BURIAL PLACE

New York City

NAME OF CEMETERY

New York City

NAME OF FUNERAL HOME

John Doe

NAME OF BURIAL PLACE

New York City

NAME OF CEMETERY

New York City

NAME OF FUNERAL HOME

John Doe

NAME OF BURIAL PLACE

New York City

NAME OF CEMETERY

New York City

NAME OF FUNERAL HOME

John Doe

NAME OF BURIAL PLACE

New York City

NAME OF CEMETERY

New York City

NAME OF FUNERAL HOME

John Doe

NAME OF BURIAL PLACE

New York City

NAME OF CEMETERY

New York City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director. After the funeral director has been signed by the attending physician and coroner, the certificate has been signed by the attending physician and coroner. Pages 1 and 2 should be filed with the funeral director. After the funeral director has been signed by the attending physician and coroner, the certificate has been signed by the attending physician and coroner. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file the original in the registrar's office. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5.6.9 Filing 233 8-29-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08727

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN TB <u>10</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		d. STREET ADDRESS <u>110 MAPLE AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Thomas Slavin</u>		4. DATE OF DEATH Month Day Year <u>8 / 22 / 58</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx.</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PANTAR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH SLAVIN</u>		14. MOTHER'S MAIDEN NAME <u>BROGET CLISHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Elvy Slavin</u>		Address <u>Severna Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 53</u> , to <u>August 22, 19 58</u> , that I last saw the deceased alive on <u>August 22, 19 58</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis I. Codd</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Severna Park, Maryland</u> <u>8-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Kelch Highway</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Scharf</u>		ADDRESS <u>1318 Leg...</u>	
24a. REC'D BY REGISTRAR <u>Aug 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

8736 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARNES CREEK</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 1536.2	
3. NAME OF DECEASED (Type or print) <u>CARROLL</u> First <u>E. A. ROL</u> Middle <u>M. SMITH</u> Last <u>SR</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 6, 1948</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOLBOY</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CARROLL M. SMITH</u>		14. MOTHER'S MAIDEN NAME <u>NAOMI SAMPSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CARROLL M. SMITH, 753 N. HAMPTON DR., SILVER SPRING</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Summary of Harnes Creek</u>	
20c. TIME OF INJURY Month, Day, Year <u>8/21, 1958</u> Hour <u> </u> a. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Harnes Creek</u>		20f. (City or town) (County) (State) <u>Alco MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>8/21/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08729

8737

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 98-1556.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARNESS CREEK</u>		d. STREET ADDRESS <u>753 Hampton Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>GARY</u> Middle <u>S</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 19, 1950</u>
9. AGE (In years last birthday) <u>8</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>21</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOLBOY</u>	
11. BIRTHPLACE (State or foreign country) <u>BETHESDA, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CARROLL M. SMITH</u>		14. MOTHER'S MAIDEN NAME <u>NAOMI SAMPSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CARROLL M. SMITH, 753 N. HAMPTON DR., SILVER SPRING</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Summery of Harness Creek</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a. m. <u>21</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Harness Creek</u>	
20f. (City or town) <u>AA CO</u>		(County) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8662 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1
+
M
00
I
2
2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Manhattan Manor				d. STREET ADDRESS Manhattan Manor			
3. NAME OF DECEASED (Type or print) First CHARLES Middle JOSEPH "BUCK" Last SNYDER				4. DATE OF DEATH Month August Day 28 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/30/12		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Dispatcher for		10b. KIND OF BUSINESS OR INDUSTRY C&R Paint Supply		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Snyder				14. MOTHER'S MAIDEN NAME Agnes Holpman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Amalia Snyder (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 Myocardial infarction due to arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-1-58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Lernard J Luck				ADDRESS 3305 Harford		24a. REC'D BY REGISTRAR DATE SEP 2 '58	
				24b. REGISTRAR'S SIGNATURE Clifford S. Thomas			

FOR STATE
HEALTH DEPT

1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		35		Male		White		1950		Los Angeles, Cal.	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
123 Main St.		Teacher		Heart Disease		Natural		10:00 AM		[Signature]	
City		County		Hospital		Physician		Burial		Remarks	
Los Angeles		Los Angeles		St. Mary's		Dr. Smith		Crematory		None	
State		Federal		Social Security		Insurance		Other		Notes	
Calif.		U.S.		123-456789		ABC Insurance Co.		None		See Report	
Birth Date		Birth Place		Married		Widowed		Divorced		Single	
1915		New York		Yes		No		No		No	
Father's Name		Mother's Name		Education		Religion		Ethnicity		Other	
John Doe		Jane Doe		High School		Catholic		Italian		None	
Occupation		Education		Religion		Ethnicity		Other		Notes	
Teacher		High School		Catholic		Italian		None		See Report	
Cause of Death		Manner of Death		Time of Death		Signature of Examiner		Burial		Remarks	
Heart Disease		Natural		10:00 AM		[Signature]		Crematory		None	
Hospital		Physician		Burial		Remarks		Other		Notes	
St. Mary's		Dr. Smith		Crematory		See Report		None		See Report	
Social Security		Insurance		Other		Notes		Remarks		Other	
123-456789		ABC Insurance Co.		None		See Report		None		See Report	
Birth Date		Birth Place		Married		Widowed		Divorced		Single	
1915		New York		Yes		No		No		No	
Father's Name		Mother's Name		Education		Religion		Ethnicity		Other	
John Doe		Jane Doe		High School		Catholic		Italian		None	
Occupation		Education		Religion		Ethnicity		Other		Notes	
Teacher		High School		Catholic		Italian		None		See Report	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08731

Reg. Dist. No.

8738

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, without the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>22 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 126 Pawhattan Beach rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Sommers Sommers</u>				4. DATE OF DEATH Month Day Year <u>August 2rd. 19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/8/74</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired piano polisher.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Riga, Latvia, Europe.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Theodore J. Sommers (son).</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X HYPERTENSIVE + ARTERIOSCLEROTIC</u> DUE TO <u>CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Paul F. Guerin</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PAUL F. GUERIN</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. County MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u>				24a. REC'D BY REGISTRAR <u>Aug 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul F. Guerin</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

12078

10758

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10758		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Arnold, Md.		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby		First Boy		Middle STRATMANN		Last STRATMANN		4. DATE OF DEATH Month Aug. 8		Day 12		Year 19 58							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/58		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1		IF UNDER 24 HRS. Days 30							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Albert Eugene STRATMANN								14. MOTHER'S MAIDEN NAME Mary Jane SILTMAN											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Father				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 x DUE TO (Weight at birth 4 3/4 oz.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH 1' 30"							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 12, 1958 to Aug. 12, 1958 , that I last saw the deceased alive on Aug. 12, 1958 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 69 Franklin St., Annapolis, Md. DATE SIGNED 11/26/58																			
ACTUAL SIGNATURE Robert A. Riley, Jr.				PHYSICIAN'S NAME (Type) Robert A. Riley, Jr. Annapolis, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURY DISPOSED OF BY THE HOSPITAL.				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE								ADDRESS				24a. REC'D BY REGISTRAR DATE				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

2063 291xv2

CERTIFICATE OF DEATH

1568

PLACE OF DEATH HOME - 1568		DATE OF DEATH 1915	
NAME OF DECEASED JAMES J. JONES		SEX Male	
AGE 55		OCCUPATION Farmer	
PLACE OF BIRTH Maryland		DATE OF BIRTH 1860	
CAUSE OF DEATH Heart Failure		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. J. Jones		SIGNATURE OF WITNESSES J. J. Jones	
SIGNATURE OF DECEASED J. J. Jones		SIGNATURE OF NEXT OF KIN J. J. Jones	
SIGNATURE OF CLERK J. J. Jones		SIGNATURE OF REGISTRAR J. J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08732

8739

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 313 Seward Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn Park (25)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 1 313 Seward Avenue	
3. NAME OF DECEASED (Type or print) First Antoni Middle E. Last Szymanski		4. DATE OF DEATH Month August Day 14 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Tailor	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Karl Szymanski		14. MOTHER'S MAIDEN NAME Anna Sterlecki	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-4325	
17. INFORMANT Mrs Helen Fowler		Address 313 Seward Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151x gastro hemorrhage DUE TO Co of the stomach, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gastro hemorrhage DUE TO (c) Co of the stomach,			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-13 , 19 57 , to 8-14 , 19 57 , that I last saw the deceased alive on 8-13 , 19 57 , and that death occurred at 7 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Eugene Schmitz		M.D.	
PHYSICIAN'S NAME (Type) Eugene Schmitz			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 403 S. Wolfe St.		24a. REC'D BY REGISTRAR AUG 15 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hand	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8691

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>51 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. ARUNDEL Gen Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS EDWARD TASKER</u>		4. DATE OF DEATH Month Day Year <u>AUG 11 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 MARCH 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE PDS COMM.</u>	9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS DIGGS</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or up/down) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-3463</u>	
17. INFORMANT Address <u>THOMAS EDWARD TASKER JR</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT BRONCHOPNEUMONIA & PULMONARY EDEMA & HYDROTHORAX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>138.1</u> (b) <u>LETAL MIDLINE GRANULOMA & PULMONARY EXTENSION</u> (c) <u>14 DAYS</u> 3 MOS		INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X POSSIBLE TUMOR OF RIGHT ADRENAL GLAND</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 MAY</u> , 1958, to <u>11 AUG</u> , 1958, that I last saw the deceased alive on <u>10 AUG</u> , 1958, and that death occurred at <u>1:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>59 FRANKLIN ST, ANNAPOLIS MD</u> DATE SIGNED <u>John B. Reddy</u>			
ACTUAL SIGNATURE <u>John B. Reddy</u>		M.D. <u>59 FRANKLIN ST, ANNAPOLIS MD</u>	
PHYSICIAN'S NAME (Type) <u>John B. Reddy M.D.</u>		<u>59 FRANKLIN ST ANNAPOLIS MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8-14-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chews Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reeder</u>		ADDRESS <u>#108 North St. Annapolis, Md</u>	
24a. REC'D BY REGISTRAR <u>AUG 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Calvin S. Kline</u>	

CERTIFICATE OF DEATH

08734

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH Annapolis, Md.		/ d. STREET ADDRESS RFD 4 Box 109 Annapolis (St. Margaret's) e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Anna Middle (n) Last TOROVSKY		4. DATE OF DEATH Month August Day 27 Year 1958	
5. SEX F	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-1864
9. AGE (In years last birthday) yrs. 94		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME (Unknown) RUZICKA		14. MOTHER'S MAIDEN NAME (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT USNH Annapolis, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Mos 6 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9 Fracture, right hip		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, . Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-13 , 1958, to 8-27 , 1958, that I last saw the deceased alive on 8-26 , 1958, and that death occurred at 9:30A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) USNH Annapolis, Maryland DATE SIGNED 8-27-58	
PHYSICIAN'S NAME (Type) M. J. MILLER LT MC USNH			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug 29 1958	National Cent	Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		24a. REC'D BY REGISTRAR [Signature] DATE SEP 3 '58	
24b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>28 Calvert Street</u>	
3. NAME OF DECEASED (Type or print) <u>Herman Albert Syler</u>		4. DATE OF DEATH <u>8</u> Month <u>6</u> Day <u>1958</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1914</u> 44 yrs.
9. AGE (in years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Syler</u>		14. MOTHER'S MAIDEN NAME <u>Roscoe Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>NO-2</u>		16. SOCIAL SECURITY NO. <u>219-16-1287</u>	
17. INFORMANT <u>Lorette Syler</u>		Address <u>28 Calvert St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>While swimming</u> (c) <u>While swimming</u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While swimming</u>	
20c. TIME OF INJURY Month, Day, Year <u>8/6/58</u> Hour <u>8</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) <u>Wentworth</u>		20f. (City or town) <u>Annapolis</u> (County) <u>Prince Georges</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. L. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Reese #108 Wash St. Annap. Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 12 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

FOR STATE
HEALTH DEPT

20

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. OCCUPATION <i>Teacher</i>		5. RESIDENCE <i>123 Main St, Boston</i>		6. DATE OF DEATH <i>Jan 15, 1920</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF DEATH <i>Home</i>	
10. SIGNATURE OF EXAMINER <i>[Signature]</i>		11. SIGNATURE OF ATTENDING PHYSICIAN <i>[Signature]</i>		12. SIGNATURE OF CORONER <i>[Signature]</i>	
13. SIGNATURE OF JURY <i>[Signature]</i>		14. SIGNATURE OF WITNESSES <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	

8694

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A-H General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dianne</u> Middle <u>Umlandt</u> Last <u>Umlandt</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 9, 1958</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Willi Rudolf Umlandt</u>				14. MOTHER'S MAIDEN NAME <u>Lissy Maria Weiss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Sylvan Shores, Riva, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythra leucostriata Fatalis</u> <u>770.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/9</u> , 19 <u>58</u> , to <u>8/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>58</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip Briscoe</u> M.D.				ADDRESS (Street, city or town, state) <u>95 Cal. Ave. St</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Philip Briscoe</u>				<u>Baltimore, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEMET.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME - ANNAPOLIS, MD</u> ADDRESS				24a. RECEIVED BY REGISTRAR <u>AUG 14 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063282XU7

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08738

8740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>15 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cyril and Orchard Ave. Green Haven</u>				d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>Audrey Emma Vogel</u>			4. DATE OF DEATH <u>Aug. 22/1958</u>		
5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11/3/18</u>		
9. AGE (In years last birthday) <u>39</u> yrs.			IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitress in school</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>School Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			13. FATHER'S NAME <u>Robert Brown</u>		
14. MOTHER'S MAIDEN NAME <u>Dora Miles</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>✓</u>			17. INFORMANT <u>Mr. Clarence E. Vogel (husband)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4-20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>gave rise to the underlying cause last.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>8/22/58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem.</u>	
22d. LOCATION (City, town, or county) <u>Ritchie Highway Md.</u>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Raus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. Fill in pages 1 and 2 of the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8741

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel Beach</u>		c. LENGTH OF STAY IN 1b <u>3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>M.</u> Last <u>WAGNER</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> , Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>August Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Susan Gettier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. Amelia Sutton - 2409 Ken Oak Rd. Balto.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYO CARDIAL FAILURE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>SENILITY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 30</u> , 19 <u>58</u> , to <u>Sept. 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 30</u> , 19 <u>58</u> , and that death occurred at <u>5:15</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.S. Chalfant</u>		DATE SIGNED <u>6210 YORK ROAD. 12. Sept. 1958</u>	
PHYSICIAN'S NAME (Type) <u>A.S. CHALFANT</u>		M.D. <u>6210 YORK ROAD. 12. Sept. 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickeney & Sons - Balto. 17 Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05/10/1935"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "11/10/1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		YEAR [Faint text, possibly "1955"]	

BALTIMORE
 MARYLAND
 DEPARTMENT OF HEALTH

8742

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in 1b 3yr. 8mo. & 17da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES EDWARD WASHINGTON		4. DATE OF DEATH Month August Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 2, 1891
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Washington		14. MOTHER'S MAIDEN NAME Sarah Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia with Septicemia 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infected toes of right foot with Gangrene. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility, Chronic Brain Syndrome, Generalized & Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/5 , 19 58 , to 8/19 , 19 58 , that I last saw the deceased alive on 8/19 , 19 58 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED 8/19/58 Crownsville, Maryland ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug. 23, 1958		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Baptist		22d. LOCATION (City, town, or county) (State) Marbury Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. Home		24a. REC'D BY REGISTRAR AUG 25 '58	
ADDRESS Weldor Md.		24b. REGISTRAR'S SIGNATURE Christ E. Munn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/18
L. J. J.

iv

Item 9 FillmG233 9-4-58 et

8743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Cape St Clair</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY E. Weaver</u>		4. DATE OF DEATH <u>8. 25</u> - 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (1873) <u>30 Oct 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Jefferson Township</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Cyrus W. Stephenson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Melvin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Daughter Mrs. Leonard</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> DUE TO <u>Gen. Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen. Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>1958</u> 19 <u>58</u> , that I last saw the deceased alive on <u>8-20-58</u> , 19 <u>58</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>8-24-58</u> ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 28-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]

DEPARTMENT OF HEALTH
STATE OF MARYLAND
BALTIMORE
1912
12-26
12-27
12-28
12-29
12-30
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100
2101
2102
2103
2104
2105
2106
2107
2108
2109
2110
2111
2112
2113
2114
2115
2116
2117
2118
2119
2120
2121
2122
2123
2124
2125
2126
2127
2128
2129
2130
2131
2132
2133
2134
2135
2136
2137
2138
2139
2140
2141
2142
2143
2144
2145
2146
2147
2148
2149
2150
2151
2152
2153
2154
2155
2156
2157
2158
2159
2160
2161
2162
2163
2164
2165
2166
2167
2168
2169
2170
2171
2172
2173
2174
2175
2176
2177
2178
2179
2180
2181
2182
2183
2184
2185
2186
2187
2188
2189
2190
2191
2192
2193
2194
2195
2196
2197
2198
2199
2200
2201
2202
2203
2204
2205
2206
2207
2208
2209
2210
2211
2212
2213
2214
2215
2216
2217
2218
2219
2220
2221
2222
2223
2224
2225
2226
2227
2228
2229
2230
2231
2232
2233
2234
2235
2236
2237
2238
2239
2240
2241
2242
2243
2244
2245
2246
2247
2248
2249
2250
2251
2252
2253
2254
2255
2256
2257
2258
2259
2260
2261
2262
2263
2264
2265
2266
2267
2268
2269
2270
2271
2272
2273
2274
2275
2276
2277
2278
2279
2280
2281
2282
2283
2284
2285
2286
2287
2288
2289
2290
2291
2292
2293
2294
2295
2296
2297
2298
2299
2300
2301
2302
2303
2304
2305
2306
2307
2308
2309
2310
2311
2312
2313
2314
2315
2316
2317
2318
2319
2320
2321
2322
2323
2324
2325
2326
2327
2328
2329
2330
2331
2332
2333
2334
2335
2336
2337
2338
2339
2340
2341
2342
2343
2344
2345
2346
2347
2348
2349
2350
2351
2352
2353
2354
2355
2356
2357
2358
2359
2360
2361
2362
2363
2364
2365
2366
2367
2368
2369
2370
2371
2372
2373
2374
2375
2376
2377
2378
2379
2380
2381
2382
2383
2384
2385
2386
2387
2388
2389
2390
2391
2392
2393
2394
2395
2396
2397
2398
2399
2400
2401
2402
2403
2404
2405
2406
2407
2408
2409
2410
2411
2412
2413
2414
2415
2416
2417
2418
2419
2420
2421
2422
2423
2424
2425
2426
2427
2428
2429
2430
2431
2432
2433
2434
2435
2436
2437
2438
2439
2440
2441
2442
2443
2444
2445
2446
2447
2448
2449
2450
2451
2452
2453
2454
2455
2456
2457
2458
2459
2460
2461
2462
2463
2464
2465
2466
2467
2468
2469
2470
2471
2472
2473
2474
2475
2476
2477
2478
2479
2480
2481
2482
2483
2484
2485
2486
2487
2488
2489
2490
2491
2492
2493
2494
2495
2496
2497
2498
2499
2500
2501
2502
2503
2504
2505
2506
2507
2508
2509
2510
2511
2512
2513
2514
2515
2516
2517
2518
2519
2520
2521
2522
2523
2524
2525
2526
2527
2528
2529
2530
2531
2532
2533
2534
2535
2536
2537
2538
2539
2540
2541
2542
2543
2544
2545
2546
2547
2548
2549
2550
2551
2552
2553
2554
2555
2556
2557
2558
2559
2560
2561
2562
2563
2564
2565
2566
2567
2568
2569
2570
2571
2572
2573
2574
2575
2576
2577
2578
2579
2580
2581
2582
2583
2584
2585
2586
2587
2588
2589
2590
2591
2592
2593
2594
2595
2596
2597
2598
2599
2600
2601
2602
2603
2604
2605
2606
2607
2608
2609
2610
2611
2612
2613
2614
2615
2616
2617
2618
2619
2620
2621
2622
2623
2624
2625
2626
2627
2628
2629
2630
2631
2632
2633
2634
2635
2636
2637
2638
2639
2640
2641
2642
2643
2644
2645
2646
2647
2648
2649
2650
2651
2652
2653
2654
2655
2656
2657
2658
2659
2660
2661
2662
2663
2664
2665
2666
2667
2668
2669
2670
2671
2672
2673
2674
2675
2676
2677
2678
2679
2680
2681
2682
2683
2684
2685
2686
2687
2688
2689
2690
2691
2692
2693
2694
2695
2696
2697
2698
2699
2700
2701
2702
2703
2704
2705
2706
2707
2708
2709
2710
2711
2712
2713
2714
2715
2716
2717
2718
2719
2720
2721
2722
2723
2724
2725
2726
2727
2728
2729
2730
2731
2732
2733
2734
2735
2736
2737
2738
2739
2740
2741
2742
2743
2744
2745
2746
2747
2748
2749
2750
2751
2752
2753
2754
2755
2756
2757
2758
2759
2760
2761
2762
2763
2764
2765
2766
2767
2768
2769
2770
2771
2772
2773
2774
2775
2776
2777
2778
2779
2780
2781
2782
2783
2784
2785
2786
2787
2788
2789
2790
2791
2792
2793
2794
2795
2796
2797
2798
2799
2800
2801
2802
2803
2804
2805
2806
2807
2808
2809
2810
2811
2812
2813
2814
2815
2816
2817
2818
2819
2820
2821
2822
2823
2824
2825
2826
2827
2828
2829
2830
2831
2832
2833
2834
2835
2836
2837
2838
2839
2840
2841
2842
2843
2844
2845
2846
2847
2848
2849
2850
2851
2852
2853
2854
2855
2856
2857
2858
2859
2860
2861
2862
2863
2864
2865
2866
2867
2868
2869
2870
2871
2872
2873
2874
2875
2876
2877
2878
2879
2880
2881
2882
2883
2884
2885
2886
2887
2888
2889
2890
2891
2892
2893
2894
2895
2896
2897
2898
2899
2900
2901
2902
2903
2904
2905
2906
2907
2908
2909
2910
2911
2912
2913
2914
2915
2916
2917
2918
2919
2920
2921
2922
2923
2924
2925
2926
2927
2928
2929
2930
2931
2932
2933
2934
2935
2936
2937
2938
2939
2940
2941
2942
2943
2944
2945
2946
2947
2948
2949
2950
2951
2952
2953
2954
2955
2956
2957
2958
2959
2960
2961
2962
2963
2964
2965
2966
2967
2968
2969
2970
2971
2972
2973
2974
2975
2976
2977
2978
2979
2980
2981
2982
2983
2984
2985
2986
2987
2988
2989
2990
2991
2992
2993
2994
2995
2996
2997
2998
2999
3000
3001
3002
3003
3004
3005
3006
3007
3008
3009
3010
3011
3012
3013
3014
3015
30

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8695

CERTIFICATE OF DEATH

08742

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bay Ridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Annapolis Gen'l Hospital		d. STREET ADDRESS 187 Bay Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle Z. Last WILSON		4. DATE OF DEATH Month Aug. Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1868
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Store - Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co., Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Wilson		14. MOTHER'S MAIDEN NAME Martha Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mattie D. Gates		Address 4607 Ridge Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Cerebral Aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH about 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-7-58 , 19____, to 8-7-58 , 19____, that I last saw the deceased alive on 8-7-58 , 19____, and that death occurred at 12:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. T. Allen M.D.		DATE SIGNED 6-1-58	
PHYSICIAN'S NAME (Type) A T ALLEN		Annapolis, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/11/58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickert		ADDRESS Baltimore - 12, Md.	
24a. REC'D BY REGISTRAR AUG 8 1958		24b. REGISTRAR'S SIGNATURE Wm. J. Lickert	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the funeral director. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8744

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BASADENA</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>325 CHERRY LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES B. WOODWARD</u>		4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	9. AGE (In years last birthday) <u>93</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Family</u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>420.0</u> DUE TO <u>Atherosclerotic Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> , to <u>August 31, 1958</u> , that I last saw the deceased alive on <u>August 31, 1958</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Brooklyn, Md</u> DATE SIGNED <u>SEP 3 '58</u>			
ACTUAL SIGNATURE <u>Louis J. Glass</u> M.D.		DATE SIGNED <u>SEP 3 '58</u>	
PHYSICIAN'S NAME (Type) <u>Louis J. Glass, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9-3-58</u>	<u>Cedar Hill Cem</u>	<u>Brooklyn, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCall Funeral Home</u>		24a. REC'D BY REGISTRAR <u>130 E Fort Ave</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Zion Lothian P.O.	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Moses Last Woodward, Jr.		4. DATE OF DEATH Month August Day 14 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) yrs. 2 Months 2 Days 13 Hours 13 Min.
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Moses Woodward		14. MOTHER'S MAIDEN NAME Irene Olive Estep	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	17. INFORMANT Mother Address Lothian, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adilectasis- DUE TO 759.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congenital deformity of chest? DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-14 , 19 58 , to 8-14 , 19 58 , that I last saw the deceased alive on 8-13 , 19 58 , and that death occurred at 5 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Emily H. Wilson		ADDRESS (Street, city or town, state) Lothian, Md. DATE SIGNED 8-14-58	
PHYSICIAN'S NAME (Type) Emily H. Wilson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 15, 58	22c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery	22d. LOCATION (City, town, or county) (State) Mt Zion, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR DATE AUG 19 '58	24b. REGISTRAR'S SIGNATURE Arthur E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063161XU2

